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No. 80-1417

In the Supreme Court of the United States

OCTOBER TERM, 1980

MARK J. MILLS, MICHAEL GILL AND WILLIAM MALAMUD,
PETITIONERS,

v.

RUBIE ROGERS, ABLE BOLDEN, BETTY BYBEL, JAMES COLLERAN, DONNA HUNT, WILLIE WADSWORTH, AND HAROLD WARNER,
RESPONDENTS.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIRST CIRCUIT

JOINT APPENDIX

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PETITION FOR CERTIORARI FILED FEBRUARY 20, 1981
CERTIORARI GRANTED APRIL 20, 1981

TABLE OF CONTENTS

	Page
I. RELEVANT DOCKET ENTRIES	1
II. RELEVANT FINDINGS AND OPINIONS	13
A. The Opinion of the United States District Court, District of Massachusetts (See *App. to Pet. for Cert.*, pp. 42a-161a)	
B. The Order and Judgment of the United States District Court, District of Massachusetts (See *App. to Pet. for Cert.*, pp. 162a-163a)	
III. THE JUDGMENT, ORDER AND DECISION IN QUESTION	14
A. Opinion of the United States Court of Appeals for the First Circuit (See *App. to Pet. for Cert.*, pp. 1a-39a)	
B. Judgment of the United States Court of Appeals for the First Circuit (See *App. to Pet. for Cert.*, pp. 40a-41a)	
C. Order of United States Court of Appeals for the First Circuit Refusing to Clarify Judgment (See *App. to Pet. for Cert.*, pp. 164a-165a)	
IV. RELEVANT MASSACHUSETTS STATUTES	15
A. Massachusetts General laws, c. 123, §§ 1, 4, 7, 8, 23, 25 (See *App. to Pet. for Cert.*, pp. 182a-194a)	
B. Massachusetts General Laws, c. 123, §§ 2, 12, 21	15
V. RELEVANT MASSACHUSETTS DEPARTMENT OF MENTAL HEALTH (DMH) REGULATIONS	20
A. DMH Regulations §§ 220.02, 223.03 (See *App. to Pet. for Cert.*, pp. 194a-196a)	

Page

B. DMH Regulations § 4.05, 200.01, 220.01, 220.03, 220.05-.08, 221.01, 221.02-.06, 222.04, 222.05, 223.02 20

VI. SELECTED PORTIONS OF DMH NEW PATIENT ADMISSION PACKET 26

VII. DR. GILL'S ANSWER TO THIRD SET OF INTERROGATORIES, QUESTION #14 39

VIII. TRANSCRIPTS

A. Selected Portions of Transcript of Trial, September 7, 1978 48

B. Selected Portions of Transcript of Trial, October 11, 1978 49

C. Selected Portions of Transcript of Trial, October 20, 1978 49

D. Selected Portions of Transcript of Trial, November 3, 1978 50

E. Selected Portions of Transcript of Trial, November 7, 1978 52

F. Selected Portions of Transcript of Trial, January 15, 1979 53

G. Selected Portions of Transcript of Trial, January 18, 1979 61

H. Transcript of Hearing of December 18, 1980 (See *App. to Pet. for Cert.*, pp. 166a-180a)

IX. RELEVANT PROPOSED FINDINGS OF FACT FILED WITH DISTRICT COURT 71

A. Symbols for Reading Plaintiffs' Proposed Findings 71

B. List of Full Titles of Medical Texts Cited in Plaintiffs' Proposed Findings 71

C. Medication 77

1. *Plaintiffs' Proposed Findings of Fact and Defendants' Rebuttal*

(I.) Introduction to Antipsychotic Medications 77

		Page
(II.)	Adverse Effects Caused by Antipsychotic Medications	80
	(A.) Tardive Dyskinesia	81
	(B.) Akathisia	87
	(C.) Pseudo Parkinsonism	89
	(D.) Akinesia	89
	(E.) Dystonia	90
	(F.) Antiparkinson Drugs for Treatment of the Neurological Side Effects	91
	(G.) Dysphoria	92
	(H.) Behavioral Toxic Reactions—Paradoxical and Pendular Reactions	93
	(I.) Adverse Effects to the Cardiovascular System	95
	(J.) Adverse Effects on Perceptual and Mental Functions	96
	(K.) Reduction of Drive, Initiative and Planning Ability	101
	(M.) Reduction in Spontaneity	103
	(N.) Induce or Reinforce Social Isolation, and Depression	104
	(O.) Reduce Ability to Experience Pleasure	105
	(P.) Autonomic Side Effects	105
	(Q.) Adverse Effects on the Endocrine System	105
	(R.) Other Risks of Antipsychotic Drugs	106
(III.)	Adverse Effects from the Antipsychotic Drugs Actually Experienced by the Named Plaintiffs and the Plaintiff Class	107

		Page
(IV.)	Why Patients Refuse Antipsychotic Drugs	113
(V.)	The Benefits of Antipsychotic Drugs Have Been Exaggerated	117
	(A.) Effectiveness of Antipsychotic Drugs	117
	(B.) Relapse Rates	121
	(C.) Antipsychotic Drugs and Its Effects on Deinstitutionalization	124
	(D.) The Need for Antipsychotics Have Been Exaggerated	125
(VI.)	Legal Conditions Under Which a Patient May Be Admitted to the Boston State Hospital	129
(VII.)	Rules and Regulations Governing Informed Consent and Civil Rights	131
(VIII.)	Circumstances in Which Patients Received Drugs Involuntarily Prior to the Court's Temporary Restraining Order	135
	(A.) The May Unit	135
	(B.) The Austin Unit	147
	(C.) The May and Austin Units	150
(IX.)	Competency of Patients	163
(X.)	Rules and Regulations Governing Competency	164
(XI.)	Practices of the Doctors in Regards to the Issues of Competency	166
(XII.)	The Involuntary or Forcible Medication of Patients in Non-Emergencies Is Not Treatment and Is Unacceptable Medical Practice	167
(XIII.)	Rules and Regulations Governing Medication Used as a Chemical Restraint	171

Page

(XIV.) Policy and Practice of the Doctors in Regards to Using Medication P.R.N. and as a Chemical Restraint..... 179

(XV.) It Is Unacceptable Medical Practice to Leave to the Discretion of the Non-physician Staff the Circumstances in Which Antipsychotic Medication Can Be Used..... 185

2. *Defendants' Proposed Findings of Fact and Plaintiffs' Rebuttal*..... 189

III. Forcible and Involuntary Medication..... 189

(A.) Forcible Medication—The Practice..... 189

1. The Practice—The Circumstances Under Which Patients Were Forcibly Medicated at the Austin and May Units..... 189

2. The Practice—Factors Influencing the Decision Whether to Forcibly Medicate a Patient at the Austin and May Units..... 196

3. Psychiatric Emergency Defined..... 197

(B.) Acceptability of Forcibly Medicating Patients in Psychiatric Emergencies, and Even in Non-emergencies..... 199

(C.) Involuntary Medication—The Practice..... 203

(D.) Acceptability of Involuntarily Medicating Patients..... 204

Page

(E.) Reasons for Forcibly and Involuntarily Medicating Patients—The Involuntary Patient Specifically 204

(G.) Reasons for Forcibly and Involuntarily Medicating Both Involuntary and Voluntary Patients 206

(1) Allowing Patients to Refuse Antipsychotic Medication Will Necessarily Curtail the Benefits of These Medications 206

(a) General Use and Effectiveness of Antipsychotic Medication .. 206

(b) Specific Beneficial Actions of Antipsychotic Medications 211

(c) Effects of Withdrawing Antipsychotic Medication from Patients Previously On the Medication 215

(d) The Societal Impact of the Use of Antipsychotic Medications. 216

(e) Antipsychotic Medications as They Relate to Other Psychiatric Therapies 218

(f) Antipsychotic Medication—Potential Negative Effects 219

Page

(2) Forced and Involuntary Medication Furthers Cooperation in Other Treatments 221

(3) The Failure to Forcibly or Involuntarily Medicate an Individual Patient Affects the Entire Milieu of the Hospital 222

(4) The Vast Majority of Patients Refusing Antipsychotic Medication Do So for Irrational Reasons Relating to Their Illness... 223

(5) Forcibly and Involuntarily Medicating a Psychotic Patient Settles the Patient Down and Reassures the Patient That Someone Will Take Care of Him, as a Classicial Symptom of Severe Mental Illness Is Ambivalence Toward Treatment 224

(6) The Decision Whether to Forcibly Medicate Should Be Left to the Doctor, Subject to Review if Abused, as It Is the Doctor, and Not a Sick Mental Patient or a Disinterested, Unavailable Guardian, Who Has the Best Interest of the Patient in Mind 225

Page

(H.) Reasons for Forcibly Medicating Both Involuntary and Voluntary Patients in Situations That Do Not Pose a Serious Threat of Personal Injury to Themselves or Others.. 226

(1) The Failure to Forcibly or Involuntarily Medicate in Situations That Do Not Pose a Serious Threat of Personal Injury to the Patient or Others Would Leave Patients To Suffer Severe Psychic Pain That Could Have Been Treated With Medication..... 226

(2) The Failure To Forcibly or Involuntarily Medicate in Situations That Do Not Pose a Serious Threat of Personal Injury to the Patient or Others Would Increase Chronicity and Lead to the Warehousing, Rather Than Treating, Those Severely Mentally Ill Patients Refusing Treatment..... 227

(3) The Failure To Forcibly or Involuntarily Medicate in Situations That Do Not Pose a Serious Threat to the Patient or Others Would Lead to an Increase in Violence in the Hospital... 228

Page

(a) All Acutely Psychotic Patients Have the Potential for Impulsively Committing a Dangerous Act..... 228

(b) The Occurrence of Violence in a Psychotic Patient Is Not Always Predictable to a Probability..... 229

(c) The Potential for Violence Would Inevitably Manifest Itself Down the Road if Patients Were Not Forcibly Medicated Before They Pose Such a Serious Threat of Violence That Staff Would Be Justified in Secluding Them..... 230

(4) Forcibly and Involuntarily Medicating Patients Only in Situations That Pose a Serious Threat of Personal Injury to Themselves or Others Would Create a Vicious Self-Defeating Cycle, in Which Patients Were Never Given Enough Medication To Keep Their Severe and Dangerous Illness From Returning..... 230

Page

(5) The Requirement To Pose a Question Other Than Whether Forcible or Involuntary Medication Is Medically Indicated Would Lead to Uncertainty on the Part of the Staff With a Concommitant Deterioration in the Condition of the Patients 232

(6) The Effects of the Temporary Restraining Order in This Case Demonstrate the Need To Allow Patients To Be Forcibly and Involuntarily Medicated in Situations Other Than Only Those Which Pose a Serious Threat of Personal Injury to the Patient or Others 233

(a) General 233

(b) The Temporary Restraining Order Required a Change in Medication Practices at the Austin and May Units 233

(c) The Change in Medication Practices Required by the Temporary Restraining Order Negatively Affected the Condition of Specific Patients 234

Page

(1) After the Issuance of the Temporary Restraining Order, Many Patients Refused Their Medication 234

(2) The Inability to Involuntarily Medicate Patients in Psychiatric Emergencies Not Constituting Threat of Violence at the Time Resulted in Acts of Violence by Some Patients Down the Road. 235

(3) Some Patients Refusing Medication Did Not Receive Inpatient Care Because the Temporary Restraining Order Prevented the Staff From Providing Adequate Treatment Which Necessarily Would Have Included the Use of Medication..... 237

(4) The Temporary Restraining Order Prevented Maintaining a Patient on a Sustained Regimen of Antipsychotic Medication To Decrease a Psychotic Process..... 238

Page

(5) The Temporary Restraining Order Resulted in Increased Lengths of Stay and Prolonged Unnecessary Psychic Suffering for Some Patients.... 239

(d) The Temporary Restraining Order Negatively Affected Ward Milieu and Interfered With the Treatment Relationships Between Patients and Staff..... 243

(e) Following the Issuance of the Temporary Restraining Order, There Has Been an Increase in the Numbers of Patients Transferred to Bridgewater State Hospital..... 245

(f) The Temporary Restraining Order Has Had a Negative Impact on the Staffing of the Austin and May Units. 246

(g) Patients Have Not Benefitted as a Result of the Temporary Restraining Order.... 247

Page

(I.) A Requirement To Obtain a Guardian Whenever a Patient Needs To be Forcibly or Involuntarily Medicated is Unworkable, Impractical and Anti-Therapeutic 265

(IX.) Medication 270

(A.) General Procedures 270

(B.) Medication P.R.N. Orders 271

(C.) The Use of Antipsychotic Medication as a Restraint 273

3. *Defendants' Rebuttal of Anticipated Plaintiffs' Rebuttal* 274

D. ELIZABETH BYBEL 275

1. *Plaintiffs' Proposed Findings of Fact and Defendants' Rebuttal* 275

(I.) Elizabeth Bybel's False Imprisonment Claim Against Defendants Gill, Kantar and Schildkrout 282

(II.) Elizabeth Bybel's Medication Malpractice and Assault and Battery Claims Against the Defendants Gill, Kantar, and Schildkrout 282

(A.) The Austin Unit as a Matter of General Practice Medicated Its Patients in Non-Emergency Situations for Many Reasons Other Than Restraining Seriously Out-of-Control Behavior 282

(B.) Elizabeth Bybel Was Medicated Involuntarily and Without Her Informed Consent by the Defendants in Non-Emergencies 282

Page

(C.) The Defendants Medication Practices Regarding Elizabeth Bybel Constituted Unacceptable Medical Practice and Harmed Her..... 296

(III.) Each of the Defendants Gill, Kantar and Schildkrout Were Aware of or Intentionally or Recklessly Avoided Their Responsibility To Be Informed That Seclusion and Medication Was Being Used Upon Elizabeth Bybel Under Circumstances Where It Was Not Privileged as an Emergency Pursuant to M.G.L. c. 123, §§ 1, 21..... 304

(A.) Dr. Gill's Responsibility for the Seclusion and Medication of Elizabeth Bybel..... 304

2. *Defendants' Proposed Findings of Fact and Plaintiffs' Rebuttal*..... 306

(I.) Her Illness..... 306

(A.) Her First Admission to the Austin Unit..... 306

(B.) Diagnosis..... 306

(C.) Her Behavior—General..... 306

(D.) Her Manic Behavior—General. 309

(E.) Her Assaultive and Violent Behavior..... 311

(F.) Her Provocative Behavior..... 312

(C.) Medication as Part of Betty Bybel's Treatment at the Austin Unit..... 313

(1) General..... 313

(2) Her Medications During the Winter of 1974..... 315

Page

(D.) Informed Consent..... 317

(2) Betty Bybel Was Informed of the Risks and Benefits of Medication..... 317

(3) Involuntary and Forcible Medication..... 319

(E.) Good Faith..... 322

(1) General..... 322
(2) Dr. Gill..... 322
(3) Dr. Kantar..... 324
(4) Dr. Schildkrout..... 324

(III.) Causation..... 326

(C.) Betty Bybel's Lack of Improvement in Late April, 1975, Was Caused by Her Repeated Escapes From the Hospital and Her Resistance to Treatment.. 326

(D.) Betty Bybel's Lack of Improvement in Late April, 1975, Was Caused By Her Refusal To Take Lithium..... 326

(IV.) Damages..... 328

(A.) Prognosis..... 328
(B.) Medication Practices..... 329

E. RUBIE ROGERS.....330

1. *Plaintiffs' Proposed Findings of Fact and Defendants' Rebuttal*..... 330

(I.) Ruby Rogers' Biographical and Medical Background..... 330

Page

(III.) Ruby Rogers' Assault and Battery Claims Against the Defendants Kahn, Cacciola, Osborne and Malamud 335

(A.) The Involuntary Use of Medication Upon the Plaintiff Ruby Rogers Was Not Privileged Since It Was Used Where an Emergency as Defined by M.G.L. c. 123, §§ 1, 21 Did Not Exist 335

(IV.) Ruby Rogers' Medication Malpractice Claims Against the Defendants Kahn, Malamud, Osborne and Cacciola 343

(A.) The Medication of Ruby Rogers Involuntarily Without Her Informed Consent Was Unacceptable Medical Practice 343

(B.) Ruby Rogers Was Harmed by the Defendants' Medication Practices 347

(V.) The Defendants Osborne, Cacciola, Malamud, and Kahn, Were Aware of or Intentionally or Recklessly Avoided Their Responsibility To Be Informed That Medication Was Being Used Upon Ruby Rogers Involuntarily Under Circumstances Where It Was Not Privileged as an Emergency Pursuant to M.G.L. c. 123, § 21 349

Page

(1.) Each of the Following Defendants Was Knowingly and Intentionally Responsible for the Involuntary Medication for Ruby Rogers..... 349

(A.) Dr. Cacciola's Responsibility for the Medication of Ruby Rogers..... 349

2. *Defendants' Proposed Findings of Fact and Plaintiffs' Rebuttal*..... 351

(I.) Her Illness..... 351

(A.) History of Prior Hospitalizations.... 351

(B.) Diagnosis..... 351

(C.) Symptoms—Thought Disorder..... 351

(D.) Symptoms—Somatic Delusions..... 352

(E.) Symptoms—Assaultive Behavior... 353

(II.) Liability..... 353

(F.) Medication—General..... 353

(1) The Prescription of Antipsychotic Medication for Rubie Rogers Was Appropriate and Necessary to Her Treatment... 353

(G.) Medication—Informed Consent.... 355

(1) Rubie Rogers Consented To Receive Antipsychotic Medications, Including the Intramuscular Administration of Antipsychotic Medications.... 355

(H.) Response to Physical Complaints... 358

(2) The Physicians of the May Unit Responded Appropriately to the Neutropenia Experienced by Rubie Rogers..... 358

Page

(III.) Causation 359

(A.) Rubie Rogers' Problems Were Caused by Her Mental Illness.. 359

(B.) Rubie Rogers' Problems Were Caused By Her Refusal of Treatment, Including Psychotropic Medications..... 359

(H.) Causation of Knots in Her Buttocks 361

(I.) Causation of a Lack of Spontaneity and Motivation..... 361

(L.) Many of Rubie Rogers' Complaints of "Side Effects" Were Not, in Fact, Side-Effects and Were Not caused by the Receipt of Antipsychotic Medications.. 361

(IV.) Damages 363

(A.) Medication Practices..... 363

(D.) Knots in Her Buttocks..... 363

(E.) Side-Effects of Medication—Neutropenia..... 364

(F.) Therapeutic Alliance..... 364

F. GENERAL FINDINGS IN REGARD TO THE PATIENT POPULATION OF THE AUSTIN UNIT..... 364

G. THE STAFFING, HIERARCHY AND ORGANIZATION OF THE AUSTIN UNIT..... 365

H. THE MAY UNIT'S HIERARCHY, ORGANIZATION, AND GENERAL STAFFING..... 369

Page

I. THE CONTEXT IN WHICH DECISIONS WERE MADE AT THE AUSTIN & MAY UNITS..... 373
(A.) The Patient Population..... 373
(B.) The Need to Prevent Escalating Violence..... 374
J. *Prediction of Dangerousness*..... 375

I. RELEVANT DOCKET ENTRIES

UNITED STATES DISTRICT COURT
FOR THE
DISTRICT OF MASSACHUSETTS

[CAPTION OMITTED IN PRINTING]

1975

Mar. 25 Complaint, received for filing; Motion for the special appointment of the server of process received for filing; Affidavit of Philip Keller; Motion for a T.R.O.; and Memorandum in support of plaintiffs' motion for a T.R.O. received for filing.

Mar. 30 *TAURO, D.J.* Case called for hearing on TRO; Affidavit of Richard Cole re notice of hearing on TRO, filed; no one appearing for the Dfts.; argument; Motion for TRO allowed and TRO order issued at 3:06 PM.

Mar. 30 Orders to show cause issued for hearing on preliminary injunction for May 8, 1976 at 10 AM.

April 8 *TAURO, D.J.* Hearing on motions; counsel for 14 Dfts. agree TRO to continue pending hearing on Prel. Inj. or permanent injunction; All Discovery to be completed by Sep. 12, 1975; Pretrial on Oct. 14, 1975 at 10 am; motion to record depositions via Tape withdrawn; dfts. (14) have until 6-20-75 to file their answers.

Sept. 12 Motion to hold a hearing to determine whether a Preliminary Injunction should issue filed, c/s.

Sept. 12 Affidavit of David Seil, filed, c/s.

Sept. 12 Affidavit of Michael Gill, filed, c/s.

Oct. 16 *TAURO, D.J.* ORDER ENTERED: It is hereby ORDERED that a class of all persons, who are presently, or will be, patients at the May and Austin Units of Boston State Hospital and who have

1975

been or will be secluded without their consent or medicated without their consent, be certified in this action pursuant to Rule 23(a) and (b) of the Federal Rules of Civil Procedure. Copies to counsel.

Oct. 21 *TAURO, D.J.* Hearing on Motion for TRO; motion to sever, assented to all parties, filed in open court (defts Goodman, Goldberg, Cacciola, Osborne, Schildkrout, Turnquest, Pomerantz, Mazmanian, Gruenberg, and Szlyk)—motion "ALLOWED"; appearance of Lee D. Goldstein, Esq. as atty for plntffs. filed in open court; Opening statements; evidence; recessed until 10:30 AM, Thursday, October 23, 1975.

Oct. 23 *TAURO, D.J.* Hearing on motion for preliminary injunction, 2nd Day; evidence continues; adjourned until Friday, October 24, 1975 at 11:30 AM.

Oct. 24 *TAURO, D.J.* Hearing on motion for Preliminary Injunction, continues, 3rd Day; evidence continues; recess at 1 PM; hearing continues at 2:55 PM; evidence continues; adjourned at 4:15 PM until Wednesday, October 28, 1975 at 2:15 PM.

Oct. 29 *TAURO, D.J.* Hearing on motion for preliminary injunction, continues 4th day; evidence; adjourned at 4:55 PM until Thursday, November 20, 1975 at 11:30 AM.

Nov. 20 *TAURO, D.J.* Hearing on motion for preliminary injunction, continues, 5th day; evidence; recess at 1 PM until 2:30 PM; Evidence continues at 2:30 PM; Adjourns at 4:00 PM until Friday, November 21, 1975 at 11:30 PM.

Nov. 21 TAURO, D.J. Hearing on motion for preliminary injunction, continues, 6th day; evidence continues; recess at 1 PM until 2:45 PM; hearing continues at 2:45 PM, evidence continues; adjourns at 4:00 PM

1975

until sometime on Monday, December 15, 1975; counsel to notify clerk on Tuesday, Dec. 2, 1975 in re consent decree progress and the amount of time needed for the Dec. 15 hearing.

1976

Dec. 30 Motion of Defts' Okin, et al to dissolve part of TRO filed, c/s.

Dec. 30 Memo in support filed, c/s.

Dec. 30 Affidavit #3 Michael Gill filed, c/s.

Dec. 30 Affidavit #3 of David Seil filed, c/s.

1977

Mar. 25 *TAURO, D.J.* Conference, Appearance of Clyde D. Bergstresser for pltfs' Hunt and Colleran filed; Arguments on Motions for summary judgment, DENIED. motion to dissolve TRO denied. Liability and damages severed. Pltf has 3 weeks to obtain permission to view records and report in writing. Agreed statement of facts and statement re interrogatories to be filed in 2 weeks. Statement of factual issues on which no agreement to be filed in 5 weeks pre-trial on 5/2/77 at 12 noon.

Mar. 30 Deft's notice of appeal filed, c/s.

April 13 *TAURO, D.J.* Order entered denying motion to dissolve TRO with attachment, copy to counsel.

Dec. 8 *TAURO, D.J.* 1st day, Curry, Reporter, (M), case called for non-jury trial on issue of liability only; plfs' opening; defts' opening; pltfs' evidence; recessed to 12/12/77 at 2:30 PM.

Dec. 9 Opinion received from the Court of Appeals entered.... The court's order denying dissolution of parts of the TRO is affirmed.

1977

Dec. 12 *TAURO, D.J.* 2nd Day, Curry Reporter (m) Civil non-jury trial continues; evidence, recessed to 12-13-77 at 10:30 AM.

Dec. 13 *TAURO, D.J.* 3rd Day, Curry, Reporter, (M), evidence recessed to 12/14/77 at 11:30 AM.

Dec. 14 *TAURO, D.J.* 4th Day, Curry, Reporter, Civil non-jury trial continues; evidence; recessed to 12/15/77 at 10:30 AM.

Dec. 15 *TAURO, D.J.* Gibbons Reporter (M), 5th Day, civil non-jury trial continues; evidence; recessed to 12-16-77 at 10:30 AM.

Dec. 16 *TAURO, D.J.* 6th Day, Curry Reporter; Civil non-jury trial continues; evidence; recessed to 12-19-77 at 10:45 AM.

Dec. 19 *TAURO, D.J.* 7th Day, Gibbons Reporter; trial continues; evidence; recessed to 1-4-78 at 10:30 AM.

Dec. 29 mandate received from the Court of Appeals entered...Affirmed. Original pleadings returned from the Court of Appeals.

1978

Jan. 4 *TAURO, D.J.* Curry AM and Gibbons PM Reporters (m) Civil Non-jury trial continues; evidence/ recessed to 1-5-78 at 10:30 AM.

Jan. 5 *TAURO, D.J.* 9th day, Curr, Reporter, (M) Civil non-jury trial continues; evidence; recessed to 1/10/78 at 10:30 AM.

Jan. 10 *TAURO, D.J.* 10th Day, Sakurai and Gibbons, Reporters (m) Civil non-jury trial continues, evidence; recessed to 1-11-78 at 10:30 AM.

Jan. 11 *TAURO, D.J.* 11th Day, Sakurai, Reporter; civil non-jury trial continues; evidence/ recessed to 1-12-78 at 10:30 AM.

Jan. 12 *TAURO, D.J.* 12th Day, Gibbons and Curry Reporters; Civil non-jury trial continues; evidence;

1978

Dr. Rosen resumed on Cross-examination; Dr. Kantar resumes on direct; recessed to 1-13-78 at 10:30 AM.

Jan. 13 *TAURO, D.J.* 13th Day, Cloonan and Gibbons Reporters; civil non-jury trial continues; evidence; Dr. Kantar resumes on direct; recessed to 1-17-78 at 10:30 AM.

Jan. 17 *TAURO, D.J.* 14th Day, Curry and Gibbons Reporters; Civil non-jury trial continues; evidence/ Dr. Kantar resumes on direct; recessed to 1-18-78 at 10:30 AM.

Jan. 18 *TAURO, D.J.* 15th Day, Curry Reporter (M); civil non-jury trial continues' evidence; Dr. Kantar resumes on direct; recessed to 1-19-78 at 10:30 AM.

Jan. 19 *TAURO, D.J.* 16th Day, Gibbons, Reporter (P) civil non-jury trial continues; evidence; Dr. Kantar resumes on direct. Dr. Henry Burkin sworn on direct; recessed to 1/20/78 at 10:30 AM.

Feb. 15 *TAURO, D.J., 17th Day,* Gibbons Reporter (M) Civil non-jury trial continues; evidence; Dr. Burkin resumes on direct, X-exam, re-direct, Re-X, recessed to 2-16-78 at 10:30 AM.

Feb. 16 *TAURO, D.J., 18th Day,* Curry and Gibbons reporters; Civil non-jury trial continues; evidence; Dr. Kauff on direct; X-exam; recessed to 2-17-78 at 10:30 AM.

Feb. 17 TAURO, D.J., 19th Day, Sakurai, Reporter; Civil non-jury trial continues; evidence; Dr. Kauff resumes on Cross; recessed to 2-22-78 at 11 AM.

Feb. 22 *TAURO, D.J. 20th Day,* Curry Reporter; civil non-jury trial continues; evidence; Elizabeth Franseen on direct; X-exam; recessed to 2-23-78 at 11 AM.

1978

Feb. 23 *TAURO, D.J. 21st Day*, Gibbons and Curry (PM) Reporters; civil non-jury trial continues; evidence; Dr. Hardman on direct; recessed to 2-24-78 at 11 AM.

Feb. 24 *TAURO, D.J.* 22nd Day, Gibbons Reporter; trial continues; evidence; Mr. Dariello on direct and cross; recessed to 3-1-78 at 10:30 AM.

Mar. 1 *TAURO, D.J. 23rd day*, Curry and Gibbons (PM) Reporters; (–) Civil trial continues; evidence; Steve Keefe on direct, X-exam; Dr. Hurley recalled; recessed to 3-2-78 at 10:30 AM.

Mar. 2 *TAURO, D.J., 24th Day*, Gibbons and Curry (PM) Reporters; civil trial continues; evidence; Dr. Goodman on direct; recessed to 3-3-78 at 10 AM.

Mar. 3 *TAURO, D.J. 25th Day*, Curry and Gibbons Reporters; civil jury trial continues; evidence/ Dr. Heller sworn on direct, X-exam; recessed to 3-7-78 at 11 AM.

Mar. 7 *TAURO, D.J., 26th Day*, Curry Reporter; trial continues; evidence; Dr. Hardman resumes on direct; X-exam; recessed to 3-21-78 at 10:30 AM.

Mar. 21 *TAURO, D.J., 27th Day*, Gibbons Reporter; Trial continues; evidence; Dr. Hardman resumes on X-exam; Rubie Rogers on direct; recessed to 3-22-78 at 10:30 AM.

Mar. 22 *TAURO, D.J. 28th Day*, Hansen Reporter; Trial continues; evidence; Rubie Rogers resumes on direct; X-exam; Mr. Keller on direct; X-exam; recessed to 3-23-78 at 11AM.

Mar. 23 *TAURO, D.J., 29th Day*, Sakurai Reporter; Trial continues; evidence; Dr. Dimaccio on direct; X-exam; recessed to 3-24-78 at 11 AM.

Mar. 24 *TAURO, D.J. 30th Day*; Curry Reporter; trial continues; evidence; Dr. Rundle on direct; X-exam; recessed to 4-11-78 at 10:30 AM; counsel to contact Clerk after March 29, 1978 to see if the date of the 11th is firm.

1978

May 4 *TAURO, D.J., 32nd Day, Curry and Gibbons Reporters*; Motion of American College of Neuro-psychopharmacologh (ACNP) for leave to file Amicus Brief, arguments; motion allowed; trial continues; evidence; Dr. Messinger resumes on direct; X-exam; recessed to 5-5-78 at 10:15 AM.

May 5 *TAURO, DJ.* 33rd day, Sakurai, Reporter; trial continues; evidence; Dr. Whittiker on direct; recessed and counsel to call clerk late Fri., 5/12/78 for possible trial on 5/16 or 5/25/78.

May 16 *TAURO, D.J.* 34th day, Curry, Reporter (AM) Gibbons, Reporter (PM) trial continued evidence; Dr. Whittiker resumes on direct; recess to 5/17/78 at 10:30 AM.

May 17 *TAURO, D.J.* 35th day, Good Reporter; trial continues; evidence; Dr. Messinger resumes on cross; re-direct; Dr. Dimassio resumes on cross; re-direct; recessed to 5/24/78 at 10:30 AM.

May 24 *TAURO, D.J., 36th Day, Curry Reporter*; Trial continues; evidence; Dr. Whittiker resumes on X-exam; recessed to 5-25-78 at 11 AM.

May 25 *TAURO, D.J., 37th Day, Curry and Sakurai, reporters*; trial continues; evidence; Dr. DiMassio resumes on re-direct; Pltff. Harold Warner on direct; No. X-exam, recessed to 5-26-78 at 11 AM.

May 26 *TAURO, D.J., 38th Day, Sakurai and Gibbons, Reporters*; trial continues; evidence; Dr. Whittiker resumes on X-exam, Re-direct, R-X, counsel to call Clerk by 4:00 PM on June 7, 1978 to find out if they are to go forward on June 8.

June 6 *TAURO, D.J., 39th Day, Curry Reporter*; trial continued; evidence; Pltff. Elizabeth Bybel on direct; X-exam; Pltff. Rests; motions to dismiss, filed and denied; Dfts' evidence; Layne U. Herschel on direct; recessed to 6-9-78 at 10:30 AM.

1978

June 9 *TAURO, D.J., 49th Day, Gibbons Reporter*; Trial continues; Mrs. Herschel resumes on direct; X-exam; re-direct; Judith Crane on direct; recessed and counsel to report to the court on Monday, June 12, 1978 as to the status of their negotiations re the injunction aspect of the case.

June 14 *TAURO, D.J.* 41st Day, Curry Reporter; Trial continues; evidence; Judith Crane resumes on direct; X-exam; re-direct; Re-X; Dr. Barbara Schildkrout on direct; X-exam; Re-direct; recessed sine die.

Sept. 7 *TAURO, D.J.* 42nd Day, Curry Reporter (E) Civil non-jury trial continues; evidence; Dr. Tarsy on direct; X-exam; re-direct; Dr. Szlyk on direct; X-exam; recessed to 9-8-78 at 10:30 AM.

Sept. 8 *TAURO, D.J.* 43rd Day Sakurai and Curry Reporters (E) Trial continues; evidence; Dr. Schildkrout on direct; X-exam; recessed to 9-12-78 at 11 AM.

Sept. 12 *TAURO, D.J.* 44th Day, Gibbons Reporter; trial continues; evidence; Dr. Schildkrout resumes on cross-examination; re-direct; recess to 9-13-78 at 11:00 AM.

Sept. 13 *TAURO, D.J.* 45th Day, Sakurai Reporter (E); trial continues; evidence; Dfts. inform the Court that they have 21 more witnesses or approx. 36 more court hours; Janet LaPierre on direct; X-exam; re-direct; recessed to 9-14-78 at 10:30 AM.

Sept. 14 *TAURO, D.J., 46th Day,* Cloonan and Gibbons Reporters; trial continues; evidence; Dr. Mazmanian on Direct; X-exam; Dr. Samraweera on direct; X-exam; re-direct; Dr. Mazmanian on X; recessed to 9-15-78 at 10:30 AM.

Sept. 15 *TAURO, D.J. 47th Day,* Good and Hansen Reporters; trial continues; evidence; Dr. Press on direct; X-exam; Re-direct; Re-Xa; recessed to 9-19-78 at 11 AM.

1978

Sept. 19 *TAURO, D.J., 48th Day,* Sakurai Reporter; trial continues; evidence; Dr. Kantar on direct; X-exam; recessed to 9-20-78 at 11 AM.

Sept. 20 *TAURO, D.J., 49th Day,* Curry Reporter; trial continues; evidence; Dr. Siegel on direct; Dr. Mazmanian on X; Dr. Siegel resumes on direct; recessed to 9-21-78 at 11:00 AM.

Sept. 21 *TAURO, D.J.,* 50th day; Mclaughlin-Reporter; trial continies; evidence; direct of Dr. Siegel continues; X-exam of Dr. Siegel; re-direct; recess at 4:00 PM to 10:30 AM on Friday, Sept. 22, 1978.

Sept. 22 *TAURO, D.J.,* 51st Day, McLaughlin Reporter; trial continues; evidence; Dr. Olin on direct; X-exam; recessed to Tues. Oct. 3, 1978 at 10:30 AM.

Oct. 3 *TAURO, D.J.* 52nd Day, Curry Reporter; trial continues; evidence; Dr. Olin on X-exam; Direct of Dr. Marneffe; X-exam of Dr. Marneffe; recessed at 4:00 PM to 10/4/78.

Oct. 4 *TAURO, D.J.,* 53rd Day, Curry Reporter; trial continues; evidence; Direct of Dr. Gair; recess at 4:00 PM to 10/5/78.

Oct. 5 *TAURO, D.J.,* 54th Day; Sakurai Reporter; trial continues; evidence; X-exam of Dr. Gair; re-direct; recess to 10/10/78.

Oct. 10 *TAURO, D.J.,* 55th Day, McLaughlin-Reporter; trial continues; evidence; Direct of Gloria Puckett; X-exam; Direct of Dr. Seil; recess to 10/11/78 at 10:00 AM.

Oct. 11 *TAURO, D.J.,* 56th Day, McLaughlin Reporter; trial continues; evidence; Direct of Dr. Cacciola; X-exam; recess at 12 Noon until further notice.

1978

Oct. 20 *TAURO, D.J.*, 57th Day, Curry-Reporter; trial continues; evidence; Direct of Dr. Brel; X-exam; continued to 10/24/78 at 10:30 AM.

Oct. 24 *TAURO, D.J.*, 58th Day, McLaughlin-Reporter; trial continues; evidence; Direct of Dr. Seil continues (see day #) X-exam of Dr. Seil; recess at 4:20 PM until 10:15 AM on 10/25/78.

Oct. 25 *TAURO, D.J.*, 59th day, Curry-Reporter; trial continues; evidence; direct of Dr. Shapiro; X-exam; Direct of Dr. Cserr; recess at 4:10 PM to 10/26/78.

Oct. 26 *TAURO, D.J.*, 60 Day, Sakurai-reporter; trial continues; evidence; X-exam of Dr. Cserr; direct of Dr. Kahn; recess at 4:15 PM to 10/27/78 at 11:00 AM.

Oct. 27 *TAURO, D.J.*, 61st day, Good-Reporter; trial continues; evidence; X-exam of Dr. Bril (see day #57); direct of Maureen Green; X-exam; recess at 1:00 PM until further notice.

Nov. 3 *TAURO, D.J., 62nd Day* (Curry Reporter); trial continues; evidence; X-exam of Dr. Kahn (see day #60); direct of Dr. Myerson; recess at 4:10 PM to Tuesday, Nov. 7, 1978 at 10:00 AM.

Nov. 7 *TAURO, D.J., 63rd Day* (Curry Reporter); trial continues; evidence; direct of Dr. Myerson; X-exam; direct of Dr. Gill; recess at 4:00 PM until further notice.

1979

Jan. 12 *TAURO, D.J.*, Civil non-jury trial continues—64th day (Curry Reporter); evidence; continued Direct of Dr. Gill; recess at 4:00 PM until 1/15/79 at 10:00 AM.

1979

Jan. 15 *TAURO, D.J.*, Civil non-jury trial continues—65th day (Curry Reporter); evidence; continued direct of Dr. Gill; recess at 4:00 PM until further notice.

Jan. 18 *TAURO, D.J.*, Civil non-jury trial continues—66th Day (Curry Reporter); evidence; continued Direct of Dr. Gill; (Gibbons Reporter); X-exam of Dr. Gill; recess at 4:05 PM until further notice.

Jan. 23 *TAURO, D.J.*, Civil jury trial continues—67th day (Curry Reporter); evidence; X-exam of Dr. Gill continues; summary of testimony of John Crumbly and Dr. Robert Sovner, filed in court; evidence continues (Gibbons Reporter); recess at 4:00 PM until 1/24/79 at 10:00 AM.

Jan. 24 TAURO, D.J. Gibbons, Civil non-jury trial cont., evidence, X-exam of Dr. Gill, re direct, re-x; direct of Marion Ford recess at 4: PM, until 1-25-79 @ 10 AM.

Jan. 25 TAURO, D.J. Curry, Civil non jury trial cont., Direct of Dorothy Cox, X exam of D. Cox, redirect; D's motion to dismiss, DENIED, Court recess @ 12:05 PM, until 1-26-79 @ 10 AM, filed.

Jan. 26 TAURO, D.J. Civil non jury trial cont., evidence, direct of Dr. R. Sovner, X exam, redirect; re-X; Court recess @ 3:10 PM, until 1-29-79 @ 10:45 AM, filed.

Jan. 29 TAURO, D.J. Civil non jury trial cont., 71st day, (HANSON) Rebuttal, evidence, direct of Eugene Crumbly, X-exam, redirect, Court recess @ 12:40 PM, until 11 AM on 1-31-79.

Jan. 31 TAURO, D.J. 72nd day, (Sakari), Civil non jury trial cont., rebuttal evidence; Court's witness; Daniel Tarsey, M.D., x-exam; P's rest on rebuttal;

1979

direct of Mark Dacy, M.D.; x-exam; re-direct; Defense rest, initial proposed findings of fact to be filed w/in 4 weeks, 3 weeks after rebuttal memos due, filed.

Aug. 13 *TAURO, D.J.* Final arguments commence; recessed to 8/14/79.

Aug. 14 Final arguments continue; concluded.

Oct. 29 *TAURO, D.J.* OPINION ENTERED; filed, cc/cl. *TAURO, D.J.* ORDER AND JUDGMENT ENTERED: For reasons set forth in Opinion issued this same date, it is ORDERED: 1) that Ds, their agents and employees, are restrained from forcibly secluding or medicating Ps and all other inpatients of Austin and May Units, and successor units, of Boston State Hosp., w/o patient's consent or consent of patient's guardian, if any, except where there is substantial likelihood of, or as result of, extreme violence, personal injury or attempted suicide; and 2) that judgment enter, and judgment is hereby entered, for Ds on all damages claims; entered, filed, cc/cl.

Nov. 19 Defts Notice of Appeal filed. c/s

UNITED STATES COURT OF APPEALS
FOR THE FIRST CIRCUIT

1980

Nov. 25 JUDGMENT OF FIRST CIRCUIT ISSUED.

II. RELEVANT FINDINGS AND OPINIONS

A. The Opinion of the United States District Court, District of Massachusetts
(See *App. to Pet. for Cert.*, pp. 42a-161a)

B. The Order and Judgment of the United States District Court, District of Massachusetts
(See *App. to Pet. for Cert.*, pp. 162a-163a)

III. THE JUDGMENT, ORDER AND DECISION IN QUESTION

A. Opinion of the United States Court of Appeals for the First Circuit
(See *App. to Pet. for Cert.*, pp. 1a-39a)

B. Judgment of the United States Court of Appeals for the First Circuit
(See *App. to Pet. for Cert.*, pp. 40A-41A)

C. Order of the United States Court of Appeals for the First Circuit Refusing to Clarify Judgment
(See *App. to Pet. for Cert.*, pp. 164a-165a)

IV. RELEVANT MASSACHUSETTS STATUTES

A. Massachusetts General Laws, c. 123, §§ 1, 4, 7, 8, 23, 25 (See *App. to Pet. for Cert.*, pp. 182a-194a)

B. Massachusetts General Laws, c. 123, §§ 2, 12, 21

Massachusetts General Laws c. 123, § 2

REGULATIONS; ADOPTION BY DEPARTMENT

The department shall, in accordance with section two of chapter thirty A and subject to appropriation, adopt regulations consistent with this chapter which establish procedures and the highest practicable professional standards for the reception, examination, treatment, restraint, transfer and discharge of mentally ill and mentally retarded persons in departmental facilities. Said regulations shall be adaptable to changing conditions and to advances in methods of care and treatment for the mentally ill, and in programs and services for the mentally retarded. For the mentally ill, said regulations (1) shall include, but not necessarily be limited to provisions for inpatient care, both during the day and at night, halfway house services, family care, aftercare and home treatment, (2) shall define the categories of mental illness for the purposes of this chapter, and (3) may provide for different procedures for specific types of patients or for particular facilities. For the mentally retarded, said regulations (1) shall include, but not necessarily be limited to, long and short-term residential care, educational services, and pre-school clinical services, (2) shall define the levels of and other aspects of mental retardation as deemed necessary by the department, and (3) shall provide for different procedures for particular facilities or programs.

Massachusetts General Laws c. 123, § 12

EMERGENCY RESTRAINT OF DANGEROUS PERSONS; APPLICATION FOR HOSPITALIZATION; DURATION; EXAMINATION; NOTICE TO DISTRICT COURT; HEARING; VOLUNTARY ADMISSIONS; DISCHARGE

(a) Any physician who is licensed pursuant to section two of chapter one hundred and twelve after examining a person has reason to believe that failure to hospitalize such person would create a likelihood of serious harm by reason of mental illness may restrain or authorize the restraint of such person and apply for the hospitalization of such person for a ten day period at a public facility or at a private facility authorized for such purposes by the department. If an examination is not possible because of the emergency nature of the case and because of the refusal of the person to consent to such examination, the physician on the basis of the facts and circumstances may determine that hospitalization is necessary and may apply therefor. In an emergency situation, if a physician is not available, a police officer, who believes that failure to hospitalize a person would create a likelihood of serious harm by reason of mental illness may restrain such person and apply for the hospitalization of such person for a ten day period at a public facility or a private facility authorized for such purpose by the department. An application for hospitalization shall state the reasons for the restraint of such person and any other relevant information which may assist the admitting physician or physicians. Whenever practicable, prior to transporting such person, the applicant shall telephone or otherwise communicate with a facility to describe the circumstances and known clinical history and to determine whether the facility is the proper facility to receive such person and also to give notice of any restraint to be used and to determine whether such restraint is necessary.

(b) If the application for hospitalization under the provisions of this section is made by a physician specifically designated to have the authority to admit to a facility in accordance with the regulations of the department, such person shall be admitted to the facility immediately after his reception. If the application is made by someone other than a designated physician, such person shall be given a psychiatric examination by a designated physician immediately after his reception at such facility. If the physician determines that failure to hospitalize such person would create a likelihood of serious harm by reason of mental illness he may admit such person to the facility for care and treatment.

(c) No person shall be admitted to a facility under the provisions of this section unless he, or his parent or legal guardian in his behalf, is given an opportunity to apply for voluntary admission under the provisions of paragraph (a) of section ten and unless he, or such parent or legal guardian has been informed (1) that he has a right to such voluntary admission, and (2) that the period of hospitalization under the provisions of this section cannot exceed ten days. At any time during such period of hospitalization, the superintendent may discharge such person if he determines that such person is not in need of care and treatment.

(d) A person shall be discharged at the end of the ten-day period unless the superintendent applies for a commitment under the provisions of sections seven and eight of this chapter or the person remains on a voluntary status.

(e) Any person may make application to a district court justice for a ten-day commitment to a facility of a mentally ill person, whom the failure to confine would cause a likelihood of serious harm. After hearing such evidence as he may consider sufficient, a district court justice may issue a warrant for the apprehension and appearance before him of the alleged mentally ill person, if in his judgment the condition or conduct of such person makes such action necessary or proper. Follow-

ing apprehension, the court shall have the person examined by a physician designated to have the authority to admit to a facility in accordance with the regulations of the department. If said physician reports that failure to hospitalize the person would create a likelihood of serious harm of mental illness, the court may order the person committed to a facility for a period not to exceed ten days, but the superintendent may discharge him at any time within the ten-day period.

Massachusetts General Laws c. 123, § 21

TRANSPORTATION OF MENTALLY ILL PERSONS; RESTRAINT

Any person who transports a mentally ill or mentally retarded person to or from a facility or the I.C.U. for any purpose authorized under this chapter shall not use any restraint which is unnecessary for the safety of the person being transported or other persons likely to come in contact with him.

In the case of persons being hospitalized under the provisions of section six, the applicant shall authorize practicable and safe means of transport, including where appropriate, departmental or police transport. Each female patient being transported shall be accompanied by a female agent, nurse or attendant.

In the case of inpatients or residents in facilities of the department or the I.C.U., restraint may be used only in cases of emergency such as the occurrence of, or serious threat of, extreme violence, personal injury, or attempted suicide; provided, however, that written authorization for such restraint is given in advance by the superintendent or director of the I.C.U. or by a physician designated by him for this purpose or if the superintendent or director of the I.C.U. or by a physician designed by him for this purpose of if the superintendent or director of the I.C.U. or the designated physician is not available, nonchemical means of restraint may be used; provided, however, that said use is reported to the superintendent

or director of the I.C.U. or to the designated physician within eight hours of said use. Any use of restraint shall be reviewed at least every eight hours by said superintendent, director of the I.C.U. or physician, who shall authorize in writing its continuation or cessation and shall make a written record of the reasons for any such use and of his review.

V. RELEVANT MASSACHUSETTS DEPARTMENT OF MENTAL HEALTH (DMH) REGULATIONS

A. DMH Regulations §§ 220.02, 223.03
(See *App. to Pet. for Cert.*, pp. 194a-196a)

B. DMH Regulations § 4.05, 200.01, 220.01, 220.03, 220.05-.08, 221.01, 221.02-.06, 222.04, 222.05, 223.02.

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§ 4.05 Written treatment policies

Every facility licensed as Class II, III, IV, V, VI, VII or any combination thereof shall establish:

(a) written policies for the conduct of psychiatric services which shall be reviewed by the facility at least once annually, and which shall specifically relate to inpatient services, outpatient services, partial hospitalization (day care and night care), emergency care, and any other service provided by the facility; and

(b) written policies for administration of any type of somatic therapy other than medication, including but not limited to electroconvulsive treatment which shall specifically describe standards for patient safety and for the administration of such treatment.

§ 200.01 Mental Illness

Pursuant to the authority of G.L. c. 123, s. 2, the Department is required to define the categories of mental illness for the purposes of said chapter.

(a) Involuntary commitment of a person to a mental health facility under the provisions of G.L. c. 123 requires a finding that failure to hospitalize such person would create the likelihood of serious harm by reason of mental illness. For purposes of involuntary commitment and the determination of criminal responsibility, "mental illness" shall mean a substan-

tial disorder of thought, mood, perception, orientation, or memory which grossly impairs judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands of life, but shall not include alcoholism which is defined in G.L. c. 123, s. 35.

(b) For the purposes of voluntary or conditional voluntary admission to mental health facilities in the Commonwealth, any degree of severity of a mental disorder including alcoholism may qualify a person for admission to a mental health facility at the discretion of the superintendent or other head of the facility or his designee when it is determined that such admission is necessary and appropriate.

§ 220.01 Authority

The Department is required by c. 123, § 2 to adopt regulations which establish procedures and standards for the treatment of mentally ill persons. This Part is promulgated pursuant to this authority. See 1 CHSR 26.45.

§ 220.03 Written treatment plan

As part of the treatment of a patient in a facility there shall be a written assessment of the pathology of the individual and a written, multi-disciplinary treatment plan; the treatment plan shall be implemented by the facility staff in good faith within the limits of available resources, there shall be a periodic written assessment of treatment progress; significant modifications of the treatment plan and their rationale shall be recorded by the responsible clinicians.

§ 220.05 ECT monthly reports to the Department

All facilities administering electroconvulsive treatment (ECT) to inpatients or outpatients shall file monthly reports with the Department on forms provided by the Department.

§ 220.06 Informed consent for electroconvulsive treatment

(a) Informed written consent shall be obtained from each patient, guardian or nearest relative by the treating physician on consent forms provided by the Department. The person giving consent may withdraw such consent in writing at any time.

(b) For a patient on voluntary admission status under Part 211 or conditional voluntary admission status under part 212 who is sixteen years of age or older, no person other than the patient may sign the consent form for ECT pursuant to § 220.02.

(c) A parent or nearest relative may sign the consent form for a patient under sixteen years of age, or for a patient sixteen years of age or over who has been involuntarily committed to the facility under G.L. c. 123.

(d) A court-appointed guardian may sign the consent form for a legally incompetent patient.

§ 220.07 ECT for patients under the age of sixteen

(a) Electoconvulsive treatment shall not be administered to any patient under the age of sixteen unless the Commissioner concurs and two independent Board-certified or Board-eligible child psychiatrists licensed to practice medicine in Massachusetts and not affiliated with the treating facility, examine the patient, consult with the treating physician, and concur in the administration of such treatment.

(b) The Commissioner shall base his approval of the administration of electroconvulsive treatments to patients under sixteen on the written recommendation of a Board-certified or Board-eligible child psychiatrist in the Department after such consultant's examination of the patient.

(c) Every consultation report signed by the consultant shall become a permanent part of the patient's record, and a copy of each such report, with recommendations, shall be sent to the Commissioner by the consultants on forms prescribed by the Department.

§ 220.08 Electroconvulsive treatments per year

(a) No more than thirty-five (35) electroconvulsive treatments shall be administered in any one year from the date of the first electroconvulsive treatment to the patient by the facility unless an independent Board-certified or Board-eligible psychiatrist licensed to practice medicine in Massachusetts and not affiliated with the treating facility ex-

amines the patient, consults with the treating physician, and concurs in the administration of additional electroconvulsive treatments. Any recommendation for additional electroconvulsive treatments within one year shall not exceed thirty-five (35). Every consultation report shall be signed by the consultant and be made a permanent part of the patient's record. The consultant shall send a copy of each such report, with recommendations, to the Commissioner on forms prescribed by the Department.

(b) For patients under the age of sixteen, consultation regarding treatments in excess of thirty-five (35) shall be carried out by a Board-certified or Board-eligible child psychiatrist designated by the Commissioner. Every consultation report signed by the consultant shall become a permanent part of the patient's record, and a copy of each such report, with recommendations, shall be sent to the Commissioner by the consultant on forms prescribed by the Department.

(c) For the purposes of this Part, each bilateral or unilateral treatment shall be counted as one treatment.

§ 221.01 Authority

The Department is authorized by G.L. c. 123, §§ 23 and 25 to establish additional rights for mentally ill persons in facilities licensed by or under the supervision and control of the Department. This Part is promulgated pursuant to this authority. See 1 CHSR 26.45.

§ 221.02 Civil rights

No person shall be deprived of the right to manage his affairs, to contract, to hold professional, occupational or vehicle operator's licenses, to make a will, to marry, to hold or convey property, or to vote in local, state, or federal elections solely by reason of his admission or commitment to a facility except where there has been an adjudication that such person is incompetent, or when a conservator or guardian has been appointed for such person. In the event of conservatorship, a patient's civil rights may be limited only to the extent of the conservator's adjudicated responsibility.

§ 221.03 Right to treatment

Each patient admitted to a facility shall receive treatment suited to his needs which shall be administered skillfully, safely, and humanely with full respect for his dignity and personal integrity. Each patient shall receive such medical, vocational, social and rehabilitative services as his age, condition, and abilities require to bring about an early return to his community.

§ 221.04 Right to education

The Department shall provide education and training appropriate to the needs of children under the care and treatment of the Department, and in accordance with G.L. c. 71B and the regulations promulgated thereunder.

§ 221.05 Right to change status

No person shall be admitted to a facility on a ten day involuntary commitment status pursuant to G.L. c. 123, § 12, unless he, or his parent or legal guardian on his behalf, is given an opportunity to apply for voluntary admission by the admitting staff.

§ 221.06 Adjudication of competency

Under G.L. c. 123, § 26, or as part of the periodic review conducted under G.L. c. 123, § 4 and Part 222, or under § 220.02(b), the superintendent or his designee shall give notice to the patient and his nearest living relative that a clinical recommendation has been made that there be an adjudication of the competency of such patient. The facility shall also take reasonable means to apprise persons having dealings with such patient that such recommendation has been made, or that an adjudication of competency of such patient is pending.

§ 222.04 Thorough clinical examination

For each periodic review, a "thorough clinical examination" shall include a mental status examination; a review of the patient's clinical history, including a review of the treatment plan, of response to treatment, and of medications administered; and an evaluation of general behavior and social interaction by nursing and social work personnel. For the

initial examination on admission and once in every twelve month period thereafter, a "thorough clinical examination" shall also include a physical examination.

§ 222.05 **Evaluation of competency**

For each periodic review, the legal competency of a patient shall be evaluated by the senior reviewing clinician in terms of whether he is able to manage rationally the ordinary affairs of life, and whether he is in need of guardianship or conservatorship for his protection. If the question of a patient's competency is raised by a periodic review, or pursuant to G.L. c. 123, § 26, if the superintendent or other head of the facility has reason to believe that a person who has been under the care of the Department as an inpatient for more than six months, who is not under guardianship or conservatorship, is unable to care for his property, he shall promptly notify said person's nearest living relative and recommend that the necessary steps be taken for the appointment of a guardian or a conservator. If the patient has no living relative, the superintendent or other head of the facility may file a petition as petitioner for the appointment of a guardian or conservator.

§ 223.02 **Use of restraint and seclusion**

Restraint or seclusion of patients may be used only in emergency situations where there is the occurrence of serious threat of extreme violence, personal injury, or attempted suicide.

VI. SELECTED PORTIONS OF DMH NEW PATIENT ADMISSION PACKET

BOSTON STATE HOSPITAL
INFORMATION FOR RELATIVES

Boston State Hospital serves the geographical area of Dorchester, Mattapan, West Roxbury, Roslindale and Hyde Park. It is a hospital for the treatment of the mentally disturbed. The hospital is divided into several clinical units and when a patient is admitted, he is admitted to one of these units. The decision as to which unit the patient goes is made on the basis of where he lives. The first clinical units are:

1. The Dorchester Mental Health Center Unit
2. The West-Rox-Park Mental Health Center Unit
3. The Developmental Disabilities Unit
4. The Medical-Geriatrics Unit
5. The Psycho-Social Rehabilitation Service Unit

In addition, we have two special services serving adolescents and those who have drug related problems.

1. *Dorchester Mental Health Center*—Provides mental health services to all residents of its part of the Boston State Hospital catchment area including south and central Dorchester and Mattapan. These services include preadmission evaluation, acute inpatient service, day hospital service, outpatient, consultation and education service, and primary prevention service. *Inquiries concerning inpatients (Wards H 3-4) may be made at 436-6000, ext. 317. Inquiries concerning outpatients may be made at 436-6000, ext. 306 and 307.*
2. *West-Rox-Park Mental Health Center*—provides mental health services to all residents of West Roxbury, Roslindale and Hyde Park. *Inquiries concerning inpatients may be made at 436-6000, ext. 472, 473 and 474. Inquiries concerning outpatients may be made at 364-5200.*

3. *Developmental Disabilities Unit*—Serves the needs of the mentally retarded of the area. It consists of inpatient services and allied community services. *Inquiries concerning patients may be made at 436-6000 ext. 276, 278, 503.*
4. *Medical-Geriatrics Unit*—Provides services to the aged psychiatrically ill, and medical services to those patients currently hospitalized. It has an active liaison with the Lemual Shattuck Hospital. *Inquiries concerning patients may be made at 436-6000* . . . . .
5. *The Psycho-Social Rehabilitation Center*—Serves the needs of longterm patients and offers a range of support services to patients with longterm mental disabilities both on the hospital grounds and in the community. *Inquiries concerning patients may be made at 436-6000 ext. 319 and 326.*

The two special units are the Drug Abuse Rehabilitation Center and the Adolescent Unit.

1. *The Drug Abuse Rehabilitation Center*—Treats drug dependent persons from the catchment area and referrals from other parts of the state. *Inquiries concerning patients may be made at 436-6000* . . . . .
2. *The Adolescent Unit*—Serves adolescent patients who come from the catchment area. *Inquiries concerning relatives may be made at 436-6000, ext. ____.*

OTHER MENTAL HEALTH CENTERS ON THE GROUNDS

1. *The Solomon Carter Fuller Mental Health Center* has its inpatient service in the May Building on the grounds of Boston State Hospital. The Area Director is Dr. Sanford Cohen . . . . . The Unit Director may be reached at 436-6000 ext. 451.
2. *Bay Cove Mental Health Center* has its inpatient service on the grounds of Boston State Hospital. The Area Director is Dr. Peter Randolph . . . . . The Unit Director may be reached at 426-6000 . . . . .

LEGAL CONDITIONS UNDER WHICH A PATIENT MAY BE ADMITTED TO THE BOSTON STATE HOSPITAL

Most patients are admitted under one of the following conditions:

1. Conditional Voluntary Admission (Section 10 and 11).
2. An Involuntary Temporary Hospitalization (10-day paper, Section 12).
3. Involuntary Prolonged Civil Commitment (Section 7 and 8).
4. Commitment of an Alleged Alcoholic (Section 35).
5. Admission and Retention of the Mentally Retarded.

The following paragraphs detail some of the outstanding points about the legal statuses under which a patient can be admitted. The notes on each of these statuses are not comprehensive and further details can be obtained either from the Admission Unit or from the Superintendent's Office of the hospital (telephone number 436-6000, ext. 200):

1. *Conditional Voluntary Admission (Section 10 and 11).* Most patients are encouraged to apply to the institution on a voluntary basis. Anyone 14 years or older may apply for in-patient or out-patient care and treatment for mental illness or mental retardation at this facility. Parental or guardian consent to the application is not necessary if the applicant is 16 years or older. In addition, a parent or guardian may apply on behalf of a person under 21. If a patient is admitted on a Conditional Voluntary Admission, he may be discharged after he has given a three-day notice to his caretaking physician. The protective patient may inspect and view the living quarters if he wishes.

The prospective patient will also be informed of the civil rights which he retains after admission to the facility. Each Unit has a Civil Rights Officer. If it is decided by the caretaking physician that the patient is not fit for discharge, the voluntary admission may be changed to an involuntary 10-day commitment.

2. *Involuntary Temporary Hospitalization (10-day paper) (Section 12).* A patient may be admitted under this paper if a qualified physician decides that failure to hospitalize the person would create a likelihood of serious harm by reason of mental illness.

Following the 10-day examination, if it is decided that failure to hospitalize the patient further would create a likelihood of serious harm by reason of mental illness, then the hospital may make a petition for civil commitment to the facility. This petition is made to a court and a hearing will be held if a patient or patient's relatives request one. If the patient or patient's relatives do not request a hearing, the court will act on the basis of the petition. The court may then order the patient committed for a period up to one year. The first order of commitment under this section will be valid for six months.

3. *Involuntary Prolonged Civil Commitment (Sections 7 and 8).* The Superintendent of this hospital may petition the district court for the commitment of any patient at the hospital if it has been determined by the Superintendent that failure to hospitalize the patient would create a likelihood of serious harm by reason of mental illness.

After receiving the Superintendent's request, the court will notify the patient and the patient's nearest relative or guardian.

A hearing will be held if the patient requests one. The court may then order the patient committed for a period of up to one year. The first order will be valid for six months.

4. *Commitment of an Alleged Alcoholic (Section 35).* A police officer or a physician may, by written petition to any district court, seek an order of due commitment of a person he has reason to believe is an alcoholic. If the court finds that the person is an alcoholic and that there is likelihood of serious harm because of his alcoholism, the

court may order the person committed for a period of up to 15 days. The person may be released before the expiration of the period of commitment if the Superintendent decides that his release will not result in the likelihood of serious harm.

5. *Admission and Retention of the Mentally Retarded.* All admissions of the mentally retarded shall be voluntary. After admission, mentally retarded persons may be retained involuntarily only if they are also mentally ill and their release would create a likelihood of serious harm. If such is the case, the mentally retarded person shall be required to submit a three-day notice of intention to leave. The Superintendent may then seek to retain the person by petitioning the court.

As mentioned, the above are the most commonly used methods of admission to the hospital. There are several others — mostly used by the courts. Details may be obtained by inquiring at the office of the Director of Clinical Affairs (436-6000)

PROCEDURES FOLLOWING ADMISSION:

Once a patient is admitted to a ward and an evaluation is made of his mental and physical state, the patient is then started on a course of treatment. A course of treatment may include counselling, medications, electroconvulsive treatment, and treatment of any medical condition that the patient may be found to have.

Patients are treated by a team of Mental Health Workers including a psychiatrist, psychologist, social worker and nurses. Volunteers are also used.

No medical or surgical treatments including electroconvulsive treatment are given without the consent of the patient. Following determination that the patient is ready for discharge, arrangements are made for the patient to be followed up in an out-patient clinic, either at the hospital or in

the community. Details of out-patient follow-up will be supplied to the patient and his relatives at an appropriate time.

A further manner of discharge may be to a nursing home, rest home, or half-way house. The placement of patients in such facilities as these is also by the consent of the patient.

Charges:

Effective October 1, 1974, the rates as established by the Rate Setting Commission are as follows:

In-Patient	$57.30 per day
Day Care	$11.24 per day

Billing if not done by Boston State Hospital but by the Settlement and Support Division of the Department of Mental Health.

Should there be any questions regarding billing for care, you may contact Department of Mental Health representative, George Carroll, at room 106, Barton Building (436-6000 ext. 423) or the ????? at room 104, Administration Building (436-6000 ext. ???).

WHAT TO WEAR:

During the time a patient is an in-patient in the hospital, he or she wears his or her own clothes. As there is very limited storage space, patients are advised to bring one change of clothing only.

Personal Property:

Patients are advised that the hospital can take no responsibility for personal property lost or stolen. Due to lack of storage facilities, patients are encouraged to bring as little personal property as is consistent with their comfort.

Visiting Hours:

Visiting hours of the hospital are from 2:00 P.M. to 4:00 P.M. and 6:00 P.M. to 8:00 P.M. Further arrangements may be made at the discretion of the staff of the Unit which cares for the patient.

Notice to the Relatives of Patients Admitted to Boston State Hospital from Central Administration:

We do hope that these notes have provided some helpful information for relatives of patients admitted to the hospital. If you have any further questions, you are invited to call the Director of the Office of Clinical Affairs at 436-6000 ext. 215.

s/ M.H. NELSON
M.H. Nelson, M.D.
Superintendent

October 1, 1974

000034
BSH #619 7/74

AUTHORIZATION TO REQUEST INFORMATION

BOSTON STATE HOSPITAL
591 Morton Street
Dorchester, Massachusetts 02124
436-6000

TO WHOM IT MAY CONCERN

I, _____, hereby authorize the
(Name of Patient)

_____ to release my records,
(name of hospital, clinic, agency)

including diagnosis and treatment, to BOSTON STATE HOSPITAL

_____
(Signature of patient)

Witness: _____

Date: _____

000035
BSH #613

BOSTON STATE HOSPITAL

Date:_____

I, the undersigned give permission to the Superintendent or his designated agent of the Boston State Hospital to release my hospital records to insurance carriers for reimbursement purposes. I also consent to the release of appropriate information to another hospital, clinic or agency participating in care and treatment.

Signature: _____
(patient and/or legal guardian)

Witness:_____

_____

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DEPARTMENT OF MENTAL HEALTH — EFFECTIVE NOV. 1, 1971
PROVISIONAL FORM 5A, JULY 1, 1971

COMMONWEALTH OF MASSACHUSETTS

APPLICATION FOR TEMPORARY HOSPITALIZATION

(Ref. Section 12, Chapter 123, General Laws)

To the Superintendent of the _____ Hospital.

I hereby apply for care in the above hospital for a period not exceeding ten days of _____ who, in my opinion requires hospitalization so as to avoid the likelihood of serious harm* by reason of mental illness.* . . . . . I have/have not personally examined said person. Evidence supporting my opinion includes:

_____

_____

_____

_____

_____

The following additional information is submitted:

A. Personal data regarding patient
   a. Sex
   b. Address (street, town, state)
   c. Birthdate (month, day, year)
   d. Birthplace
   e. Occupation f. Soc. Sec. No.
   g. Marital state (underline): never married, married, remarried, separated, divorced, widowed.
   h. Place and time of most recent psychiatric or retardation care (if none, so state):
   i. Prior care at this hospital (underline): yes, no.
   j. Name, address, and telephone number of husband, wife, nearest relative, or friend.

The definition of "likelihood of serious harm" which in association with mental illness justifies involuntary retention in a mental health retardation facility is as follows (G.L. 123 Sect. 1):

(1) "substantial risk of physical harm to the person himself as manifested by evidence of threats of, or attempts at, suicide or serious bodily harm; (2) a substantial risk of physical harm to other persons as manifested by evidence of homicidal or other violent behavior or evidence that others are placed in reasonable fear of violent behavior and serious physical harm to them; or (3) a very substantial risk of physical impairment or injury to the person himself as manifested by evidence that such person's judgment is so affected that he is unable to protect himself in the community and that reasonable provision for his protection is not available in the community."

B. Other relevant data which may assist the admitting physician, including medical, medication administered and reasons for restraint:

_____

_____

_____

_____

_____

Signed _____ Applicant

Print or type name of applicant:

_____

Address:

_____

Capacity of Applicant (underline):

Licensed Physician, Police Officer, Qualified Physician

Date _____ 19____

YOU HAVE THE RIGHT TO BE TREATED WITH DIGNITY AND RESPECT

YOU HAVE THE RIGHT TO PRIVACY

LIVING ARRANGEMENTS:

You have the right to:

- —wear your own clothes
- —keep and use your own personal possessions, including toilet articles
- —keep and spend a reasonable sum of money
- —have your own storage space.

VISITING RIGHTS:

You have the right to:

- —Receive visits at all reasonable times from your personal physician, your attorney, and your clergyman.
- —Receive visits from family, fiends and all other people at appropriate times.

TREATMENT RIGHTS:

You have the right to:

- —be examined and treated in privacy behind closed doors or curtains and without extra people such as medical students or policemen being present, unless you have given your consent.
- —be told in detail what is wrong with you, what alternative treatments are available, and to choose from these alternatives.
- —be informed of the risks and possible side effects of treatment, and to refuse treatment at any point.

Restraints and Seclusion: You may be restrained or secluded only in case of emergency. Such restraints or seclusion must be justified in your record, and must be reviewed by the superintendent within 8 hours.

COMMUNICATION:

You have the right to:

—use a public telephone and to make and receive confidential calls.

—be given stationery and stamp in reasonable amounts

—have letters mailed unopened to the Governor, the Commissioner, your personal physician, your attorney, your clergyman, and any court.

—write to other people, but these letters may be reviewed and their mailing restricted by the unit chief.

LEGAL MATTERS AND COURT HEARINGS:

You have the right to:

—be notified if a petition for your commitment has been brought to the district court.

—consult privately with your lawyer.

—be represented by a lawyer at a court hearing to determine if you should be retained at a mental health facility. If you do not have the money to pay for a lawyer, the court can appoint a lawyer for you.

PERSONAL AFFAIRS:

You have the right to:

—manage you own affairs

—hold a driver's license

—vote in all elections

NOTE : If any of these rights are withheld, it must be for good cause, and must be entered in your treatment record subject to the review of the superintendent.

000043

CONDITIONAL VOLUNTARY ADMISSION:

You must give written notice to the superintendent 3 days before you intend to leave the hospital. After notification, if the superintendent files a petition for court commitment because he feels it is in your best interest, you must remain in the hospital until a court decision is made.

10 DAY INVOLUNTARY HOSPITALIZATION:

You cannot leave the hospital while you are under involuntary commitment.

You may request at any time a change to voluntary status by petitioning the superintendent.

The involuntary hospitalization expires within 10 days unless the superintendent of the hospital petitions the court for a six month order of commitment, in which case you and your family will be notified by the court, and may request a judicial hearing.

PATIENT'S RIGHTS

This pamphlet is to inform you of your rights as a patient. If you have any questions, or if you feel these rights are being violated, speak to your hospital civil rights officer, Room ____. Full copies of the law are available to you in Room _____.

VII. DR. GILL'S ANSWER TO THIRD SET OF INTERROGATORIES, QUESTION #14

• • •

Q. 14. What percentage and how many patients in the Austin Unit refused their medication for prolonged periods and at least once from May 1, 1975 to the present?

Dr. Gill please state for each patient who refused their medication:

a) The patient's initials;

b) The patient's in-patient legal status (conditional, voluntary, on 10 day paper, held pending a court commitment hearing, held after being court committed, held for observation on criminal charges) at the time of the refusal. (Include more than one if applicable).

c) The dates the patient was an in-patient in your unit.

d) The length of time the patient refused his/her medication.

e) The date(s) of refusal.

f) The type, and amount of medication refused.

g) Whether the patient voluntarily assented to take the refused medication or an appropriate alternative at some point subsequent to their refusal.

h) The patient's asserted reasons for his/her refusal.

i) Whether the staff considered the patient competent or incompetent to make such a decision.

j) Whether the patient was determined to be competent or incompetent in their most recent prior periodic review.

k) Whether the staff filed a guardianship petition if the staff determined the patient was incompetent to make the decision.

(1) If filed, whether the petition was allowed.

l) Whether the staff considered the refused medication as essential to the patient's treatment.

m) Whether the patient's mental or physical condition improved, remained the same or deteriorated during the period of the refusal.

n) The extent to which the patient's mental or physical condition improved or deteriorated if at all, during the period of the refusal.

o) Detail the mental and physical condition of the patient prior to, during the period of, and subsequent to the period of refusal.

p) The number and type of violent acts committed by the patient prior to, during the period of, and subsequent to the period of refusal.

g) The number and times the patient was forcibly or involuntarily medicated because of an emergency situation prior to, during the period of, and subsequent to the period of refusal.

r) Whether the patient was transferred to another hospital or Bridgewater State Hospital during the period of the refusal (include the name of the hospital, if transferred).

s) Whether the patient was discharged as a result of their refusal to accept the prescribed medication.

t) The name, address and job title of the individual(s) who obtained the data necessary to answer this interrogatory.

u) Describe in detail the procedure by which the data necesary to answer this interrogatory was gathered and analyzed.

A. 14. I recall the following patients as having refused their medication for prolonged periods and at least once from May 1, 1975, to the present. One member of this group of patients is James Colleran, as to whom the answer to this interrogatory may be derived or ascertained from his records at the Austin Unit.

#7 was admitted to the Austin Unit on August 26, 1975. #7 became absent without authority on July 16, 1976. #7 became a voluntary on September 5, 1975. #7 refused medication (Mellaril, 200 mg.) on August 26, 1975 and August 27, 1975. #7 accepted the same medication from August 28, 1975 to September 10, 1975. #7 accepted medication (Thorazine, 100 mg.) on September 2, 1975, September 4, 1975, September 8, 1975 and September 10, 1975. Upon admission, #7 was mute and suicidal. #7 was disorganized and unable to care for self. During the four weeks subsequent to admission, #7 was flagrantly psychotic, delusional, hostile and assaultive. On August 13, 1975, August 14, 1975, August 15, 1975, August 19, 1975 and August 20, 1975, #7 was violent. #7 tried to stab self and threatened other patients. On November 28, 1975, #7 was violent. On December 17, 1975, #7 was violent. #7 refused to surrender a pair of scissors. #7 threatened to stab anyone. On January 11, 1976, #7 pinned a safety pin to #7's throat. On February 21, 1976, #7 was violent. On April 10, 1976 while accepting very little medication, #7 was assaultive and attacked staff personnel with a spoon.

#8 was admitted on August 18, 1975. #8 was assaultive and threatening. After initial struggle, #8 accepted medication (Thorazine). #8 became calm. #8 slept and was more cooperative upon awaking. #8 was discharged on August 20, 1975. #8 was next admitted on September 15, 1975 in a delusional state. #8 was unruly, homicidal, and agitating other patients. On September 22, 1975, #8 was absent without authority. On September 24, 1975, #8 was agitated, delusional and upset. On September 25, 1975, #8 was dangerous to others. #8 took medication (Thorazine) from September 25, 1975 until discharged on October 3, 1975, when #8 had become more organized. #8 was agitating to leave the hospital during this period and was provocative with staff and patients.

#9 was admitted to the Austin Unit as a voluntary patient on August 7, 1975. #9 was quite delusional. #9 was violent at

times. As of August 8, 1975, #9's behavior on the ward was unruly. On August 9, 1975, #9 agitated other patients and staff. On August 10, 1975, #9 urinated in a chair on the ward. On August 12, 1975, #9 was uncooperative for a physical examination. #9 remained uncooperative on August 13, 1975. #9 was very much out of control during the first week after admission. #9 eventually accepted lithium treatment. #9 went on an extended visit on September 17, 1975.

#9 was admitted on December 31, 1975. #9 was very depressed, extremely agitated, and manic. #9 was resistant to lithium. #9 later cooperated. #9 calmed down after #9 got back on lithium. On January 15, 1976, #9 was very suicidal, confused and depressed. #9 became nearly mute. #9 was placed on extended visit status on April 2, 1976, but was readmitted on June 24, 1976. On April 2, 1976, after #9's lithium had become stable, #9 calmed down considerably and was extremely cooperative on the ward. #9 was able to work with staff on release. On August 17, 1976, #9 was again placed on extended visit status.

#10 was admitted on September 4, 1975. #10 was assaultive and agitated upon admission. #10 became absent without authority on September 10, 1975. #10 was brought back by police on October 30, 1975 because #10 had been picking fights and assaulting people. #10 refused medications (Thorazine, 300 mg., and Ortene, 2 mg.) from November 1, 1975 to November 6, 1975. #10 was out of control during this period. #10 was discharged on November 6, 1975. #10's father called later to report the destructive and violent behavior of #10 who had been shot and killed in Detroit, Michigan, while stealing a truck.

#11 had been admitted on April 17, 1975. #11 was absent without authority on April 22, 1975. #11 was discharged on April 26, 1975. #11 had refused medication during this period. #11 was admitted on May 14, 1975. #11 was very hostile upon admission. #11 assaulted a female patient. #11 was unable to care for self. As of June 18, 1975, #11 had refused to take any medication. #11 continued to be unable to care for self and

was a serious threat to others. #11 was discharged on June 30, 1975. #11 was admitted on January 9, 1976. #11 was hostile and agitated upon admission. #11 escaped on January 19, 1976, but apparently returned. As of April 14, 1976, #11 was continuing to improve. During this period, #11 was accepting medication (Haldol, 10 mg.). #11 was discharged on October 1, 1976. #11 was discharged on October 1, 1976. #11 was admitted on October 1, 1976, escaped on October 1, 1976 and was discharged on October 10, 1976. As of October 3, 1976, #11 was very agitating, threatening and uncooperative. #11 was admitted on October 17, 1976, escaped on October 17, 1976, and was discharged on October 26, 1976. #11 was brought in by the police after #11 pulled a knife on them. #11 escaped on November 28, 1976 and was discharged on November 29, 1976. #11 was admitted on January 6, 1977 in an agitated and hostile state. #11 was discharged on January 14, 1977 while threatening and uncooperative. #11 was admitted on January 19, 1976. #11 was quite disruptive, assaultive, and suicidal. #11 escaped on January 24, 1977 and was dischaged on January 26, 1977.

#12 was admitted to the Austin Unit on January 6, 1975. #12 was an in-patient through June 30, 1975, except that #12 was discharged on application on February 18, 1975. After decompensating, #12 was escorted back to the Austin Unit by police on March 18, 1975. #12 was in the Lemuel Shattuck hospital on August 6, 1975. On September 10, 1975, #12 was returned to the Austin Unit after threatening to commit suicide. On October 26, 1975, #12 was again returned to the Austin Unit after attempting suicide by jumping in front of an M.B.T.A. train. #12 was readmitted on December 1, 1975. #12 was again admitted to the Austin Unit on January 13, 1976 after taking an overdose. #12 stopped taking medication in the last week of November 1975. #12 intermittently refused medication (Stelazine, 10 mg.) during February, 1976. #12 refused medication on March 1, 1976. Upon admission on January 6, 1975, #12 was actively hallucinating, hearing

voices, and had attacked #12's father. #12 was not then on any medication. On January 17, 1975 and January 23, 1975, #12 was assaultive. As of March 28, 1975, #12 had been sporadically out of control for the week. On April 4, 1975, April 7, 1975, April 9, 1975, April 1, 1975, and April 16, 1975, #12 was assaultive or otherwise creating problems. On May 8, 1975, #12 threatened to set fire to the home of #12's parents while #12 was on a visit. As of May 27, 1975, #12 refused to cooperate or eat. On August 6, 1975, #12 attempted to commit suicide. Upon being returned to the Austin Unit on September 10, 1975, #12 began hitting windows. As of January 18, 1976, #12 was reclusive and would not cooperate. As of February 2, 1976, #12 was acting up on the ward. #12 was slugging people and breaking windows. On February 8, 1976, February 13, 1976, February 14, 1976, February 15, 1976, and February 22, 1976, #12 was assaultive or otherwise creating problems.

#13 was admitted on September 12, 1975. #13 was signed out of the Austin Unit as absent without authority on September 23, 1975.

#13 was admitted on September 23, 1975 after being bought back by police. #13 again signed out of the unit as absent without authority on October 18, 1976. #13 refused medication subsequent to admission to the Austin Unit. #13 accepted medication (Stelazine, 10 mg.) from September 20, 1975 to September 23, 1975. #13 refused medication (Stelazine, 10 mg.) from September 24, 1975 through October 4, 1975. #13 then again accepted medication for the remainder of October, 1975. #13 accepted medication from December 1, 1975 to December 15, 1975, on December 17, 1975, and on December 28, 1975. #13 accepted medication from February 1, 1976 to February 12, 1976 and on February 29, 1976. #13 accepted Medication (Stelazine, 20 mg.) throughout April and May, 1976. #13 accepted medication throughout August and September, 1976. #13 accepted medication from October 1, 1976 through October 9, 1976. #13 accepted medication

(Stelazine, 30 mg.) on October 10, 1976 through October 18, 1976. Upon admission on September 12, 1975, #13 was confused and belligerent. Upon readmission on September 23, 1975, #13 was increasingly regressed and agitated. #13 attacked patients and staff personnel. On October 3, 1975, #13 attacked staff. On October 5, 1975 and October 6, 1975, #13 attacked and threatened to kill staff. During November, 1975, #13 tried to strangle a female patient. As of November 15, 1975, #13's affect was very labile and often inappropriate. On November 16, 1975, #13 was out of control and disturbing other patients. On November 20, 1975, #13 was disturbing other patients. On December 26, 1975, #13 was extemely assaultive and attacked patients. On December 27, 1975, and December 28, 1975, #13 was assaultive toward staff. On February 10, 1976, #13 was threatening. On February 11, 1976, #13 was out of control and assaulting other patients. On February 12, 1976, #13 assaulted staff members violently. #13 tried to strangle a staff member. This behavior continued on February 13, 1976 and February 14, 1976. #13 was extremely violent and tried to kill several people. #13 acted violently on February 19, 1976 through February 23, 1976, March 1, 1976, March 13, April 10, April 14, May 16, July 24 through July 28, 1976, August 10, August 16, September 16, September 17, October 11, October 12, October 13 through October 15, 1976, October 19, October 20, October 25, November 17, 1975, January 18, January 19, 1976, February 14, February 20, March 11, April 3, April 4, and April 7, 1977. #13 had been doing well for the past three weeks as of November 3, 1976.

#14 was admitted to the Austin Unit on November 1, 1975. #14 was discharged on November 21, 1975. #14 was again admitted on November 22, 1975. #14 escaped on March 26, 1975 and was found in New York. #14 was discharged on May 18, 1976. #14 refused medication for a prolonged period in late December, 1975. #14 was refusing to take medication from time to time during late January and/or early February, 1976. #14 was absolutely refusing to take lithium during this period. On

November 2, 1975, #14 poured hot chocolate over a patient. #14 hit a staff member and threatened to kick other staff personnel. As of November 4, 1975, #14 was still very difficult and disruptive. When brought in by police on November 22, 1975, #14 was delusional and unable to care for self. In mid-December, 1975, #14 was angry and agitated. #14 would become extremely angry and verbally abusive.

On January 6, 1976, #14 became extremely angry. On January 11, 1976, #14 tried to escape. On January 12, 1976, #14 assaulted another patient. As of January 12, 1976, #14 was becoming assaultive and/or inciting other patients to assault #14 when #14 was not taking medication. As of February 6, 1976, #14 continued to be assaultive and provocative to both patients and staff. #14 had been assaulted several times by other patients as a result of #14's verbal abuse.

#15 was admitted on October 25, 1975. #15 escaped on November 19, 1975 and returned on November 23, 1975. As of November 28, 1975, #15 was assaulting and attacking staff. #15 presented a serious management problem. On December 10, 1975, #15 attacked a staff member without provocation. The staff member required surgery. On December 19, 1975, #15 was taking medication without resistance. #15 was very cooperative. As of December 22, 1975, #15 continued to be very cooperative. On January 6, 1975, #15 was improving. As of April 14, 1976, #15 was taking medication (Thorazine, 300 mg.) and was less assaultive.

#16 was admitted on January 7, 1975. #16 was absent without authority on January 8, January 12, and January 20, 1975. #16 was discharged on June 30, 1975. #16 was admitted on July 9, 1975. #16 was admitted on March 9, 1977. #16 went on an extended visit on March 18, 1977. #16 refused medication (Navane, 10 mg.) for the period of three months after admission on July 9, 1975. #16 remained very delusional and failed to improve.

#17 was admitted to the Austin Unit on October 12, 1976. #17 escaped on December 17, 1976. #17 went on extended visit status on January 3, 1977. #17 was discharged on April 17, 1977. #17 refused all medications during the first week after admission. #17 then agreed to take medication (Chlorpromazine). #17 had been admitted after becoming beserk and assaultive. Upon admission, #17 was labile, self-destructive, hallucinating, etc. During the first week after admission, #17 slept poorly, paced and displayed threatening behavior. On October 17, 1976, #17 was violent and threatening. A gradual increase in threatening behavior occurred. On November 5, 1976, #17 threw a chair at a staff member and otherwise assaulted him. #17 was assaultive on April 12, 1977.

As to whether the staff considered the refused medication to be essential to each patient's treatment, the medication would not have been ordered if the staff did not consider it to be essential to the patient's treatment.

Scott Fredericksen, a student intern with the Department of the Attorney General, obtained the data necessary to answer this interrogatory. He examined the Austin Unit's files for those patients whom I believe to have refused their medication.

VIII. TRANSCRIPTS

A. Selected Portions of Transcript of Trial, September 7, 1978

(Testimony of John Szlyik, M.D.

* * *

[42-110] Q. Now, doctor, you have indicated that it was your practice not to authorize involuntary medication in the absence of a psychiatric emergency, is that correct? A. That is correct.

Q. Would you define "psychiatric emergency" in the way that we have discussed seclusion, namely the serious threat of or result of violence, personal injury or attempted suicide; or would it be a broader definition than that? A. State that one again.

Q. Well, define "psychiatric emergency" for me as you have used it. A. An acute psychiatric emergency is a state in which the patient is markedly disorganized and fearful and panicked, could be actually hallucinating or whatever, and is out of control and in a position where they [42-111] are potentially a threat to themselves or someone else in various ways.

Q. Would you be of a position that whenever there was such a serious psychiatric state that there was a serious threat of extreme violence, personal injury or attempted suicide? A. Yes. And the other conidition would be if somebody started refusing to eat, which isn't as overt as, say, charging a wall or cutting one's wrists or something line that, but other patients can, for instance, go into catatonia and refuse to eat. So there is a passive movement towards death, and that by not eating and being even rigid, they put themselves in a potential medical emergency; for instance, like renal shutdown or dehydration — that's another form of medical emergency — or any other kind of regressive behavior that in some way will jeopardize the patient's life.

Q. That would be personal injury, that would be a serious threat of personal injury, would it not? A. That's right. They're a threat to their own life in some medical way.

• • •

B. Selected Portions of Transcript of Trial, October 11, 1978

(Testimony of Eugene Cacciola, M.D.)

[56-30] A. Occasionally, yes, I did prescribe for medications to be given intramuscularly and occasionally against the patient's will.

Q. And did you have any criteria to indicate the circumstances in which such could be done? A. Yes. For me when a patient was out of control, that is, when their behavior was clearly escalating to a point where they would hurt someone or hurt themselves, I would order medication, tranquilizer.

Q. Did you communicate your understanding of how this should be done to the nurse and/or to the attendant staff? A. Yes, you know, I don't know if I did it every time. Because I think the staff members who were there had procedures that they were comfortable with and followed for months and years before I got there. But I had, I'm not sure exactly what you mean by "procedure," but I would — I had procedure certainly when a patient was clearly escalating in their agitation —

• • •

C. Selected Portions of Transcripts of Trial, October 20, 1978

(Testimony of Henry Brill, M.D.)

• • •

[57-22] Q. Could you, if at all, sort of capsulize what you said before in explaining chemically, if possible, how these antipsychotic drugs work? A. To begin with, we are putting a chemical into the body. You have to assume — and this is a fundamental assumption that has been well-accepted — you have to assume that the effect is due to a chemical reaction, to

a binding between the chemical and some element in the body. That was enunciated by Ehrlich a long time ago.

The question then is which chemical was binding, where does the drug bind in the body to produce the effects. And there is good reason to believe that it binds at the receptor sites, at the point where cells transmit their impluses from one cell to the other — at the synaptic cleft, the synaptic membrane — and something about that chemical reaction accounts for the changes which occur.

Now the changes occur in sequence because [57-23] a great deal of the picture that is presented by mentally sick people is not a moment-to-moment disorder but is learned as a result of distortions of emotion, distortions of mood, distortions of feeling. So that one has to wait until the primary chemical effect somehow is transmuted into the changes which we see as the improvement of the psychoses.

I don't know if that is really what you were getting at or not.

Q. It is fair to say, doctor, that these drugs act on different parts of the brain, some which deal with stimulation, some which deal with tranquilization, some which deal with psychotic thinking and that there is a sequence involved in the reaction to the different parts of the brain? A. Yes, that is quite true. The drugs obviously reach all parts of the brain and they obviously effect both the activator and inhibitor parts of the brain. And clinically, now, we see that certain effects come quickly, other effects come slowly. So there is a sequence.

* * *

D. Selected Portions of Transcript of Trial, November 3, 1978

(Testimony of Richard Kahn, M.D.)

[62-26] Now this is your response:

"It is admitted that some involuntary patients, whom I believed were not able to make rational decisions, re-

ceived psychopharmacologic and some other medications forcibly against their will and without their informed consent when the medication was not used as a restraint of last resort to deal with a serious threat of or as a result of extreme violence, personal injury or attempted suicide.

"All involuntary patients by definition under law have been committed because of the likelihood of serious harm if they are not treated."

Was that your position, Doctor, at that time?

Does this accurately reflect your position with regard to involuntarily treating involuntary patients in your unit? A. If by that you understand that the additional factor of physical deterioration, which I didn't mention here, is one of the provisos, that is, we certainly involuntarily — we medicated patients against their will with digitalis, dilantin, insulin and when we felt there would be deterioration that would be a risk [62-27] to life.

And we also medicated them with phenothiazines, not as a chemical restraint, but as a part of a treatment, an involuntary treatment applied to dangerous patients, patients who were risks to themselves and to other people.

If you would just add "physical deterioration," that captures the whole thing.

THE COURT: All right. Wait a minute.

(Discussion off the record.)

Q. Are you adding another dimension to the notion of emergency here, when you refer to physical deterioration? A. Physical deterioration means a risk to life by one's own deterioration, either by epileptic spells or by diabetic coma or by not eating.

Q. And you distinguish that from the definition of "emergency" supplied by the statute? A. No. I include that in the emergency.

Q. Nevertheless, you indicate here you involuntarily medicated involuntarily committed patients in nonemergen-

cies; isn't that what you said here? A. No. I guess by that what I meant was this additional deterioration. No, we were not medicating involuntary patients against their will when there was no emergency, and I don't really think that that says that.

* * *

[62-30] *Redirect Examination by Ms. Crothers*

Q. Doctor, were you the supervisingpsychiatrist overseeing the performance of the psychiatric residents on May 4 for the months of September of 1973 — well, leave it at that — for September of 1973? A. No, I wasn't.

Q. Were you the supervising psychiatrist overseeing the performance of the psychiatric residents on May 4 during the month of June, 1974? A. No, I wasn't.

Q. And who was that supervising psychiatrist for each of those months? A. On both occasions it was Dr. Anna Maria Soto.

Q. Mr. Burdick asked you on cross examination whether patients at the May Unit while you were its inpatient director were involuntarily medicated in non-emergencies and your answer was No.

When you so answered, how did you define the term "emergency"? A. By "emergency" I mean a situation in which the patient might be a serious threat to his own life, to the lives [62-31] of people around him, assaultive to other people or in a condition of impending physical deterioration that was going to be a risk to his life.

* * *

E. Selected Portions of Transcript of Trial November 7, 1978

(Testimony of Michael Gill, M.D.)

* * *

[63-107] Q. Approximately what percentage of the patients at the Austin Unit during the period of the lawsuit were in your opinion potentially violent? A. Well, there was a very high percentage of patients who were potentially violent.

Again, the major reason for admission is the sense of threat and violence, threatened serious disturbance that would often lead to violence.

So that there was a high percentage of patients who were potentially violent, somewhere in the range of about — at any given time — it's hard to know what is meant by "potentially violent," first of all — but I believe that patients who would be easily triggered into a violent episode, I believe, would fall in the range of about 20-25 percent, somewhere along those lines.

Patients who were actually engaged in violent behavior periodically — it's hard to know exactly — and perhaps three-five percent, something along those lines.

* * *

F. Selected Portions of Transcript of Trial, January 15, 1979
(Testimony of Michael Gill, M.D.)

* * *

[65-90] Q. Can you give examples of any specific patients who have suffered since the temporary restraining order because staff have failed to act decisively and felt constrained from in any way coercing the patients? A. Yes. And there is an example of a patient that I treated, a patient whose initials are J.T. — I think I spoke about him earlier in my testimony — and he was a patient who was admitted at various times prior to the TRO, was dealt with fairly firmly, usually would take medication somewhat reluctantly, somewhat grudgingly, but after a few days would take it voluntarily and was glad, essentially, that he had agreed to take it because it benefited him and he knew that.

After the TRO, he was admitted in the fall of '75, and at that time I think there was a hearing on the temporary restraining order, just perhaps a few days prior to his being admitted, and he came in while the unit was in a great deal of turmoil and he refused medication, agreeing only [65-91] to take librium, which is an anti anxiety agent.

Q. He refused antipsychotic medication? A. Antipsychotic medication, yes.

He agreed to take antianxiety medication, but essentially that medication was not really indicated for him. Although it was given, it really had very little effect.

During a scuffle on the ward an attendant was trying to subdue a female patient. He took the female patient aside and wrestled the attendant to the floor. That resulted in the attendant's having an injured cervical spine, which resulted in the attendant leaving the job and never coming to work again.

Q. Let me back up just a little bit.

When you say he got involved in a scuffle, was this the day after he refused medication or had he deteriorated at this point? A. It was really unclear at that point. He was in hospital for a few days at that point, and he was continuing to refuse medication.

I think he had eloped on one occasion and had come back again but was continuing to refuse.

There was a great deal of concern as to what to do: Should we force medication or should [65-92] we note?

Q. After he got involved in the scuffle, did you forcibly medicate him? A. After he got involved in the scuffle, we did not forcibly medicate him because, again, it was somewhat ambiguous because of the scuffle; that there had been provocation and that was the reason that he had wrestled the man to the floor.

We felt he was not a serious threat and he was not that violent and he could be dealt with other ways.

He then subsequently attacked another attendant, punched him in the face and fractured his zygomatic arch, one of the facial bones, which resulted in that particular attendant having to receive surgery and having to take time off from work.

The patient was then medicated and was then secluded and extremely, in my opinion, prolonged his hospitalization and also caused him to have a very severe sense of guilt over what he had done.

He was also enormously fearful of his own aggressions and was very fearful — when he eventually did leave the hospital, perhaps 8-9 months later, he was very fearful to leave the hospital.

[65-93] That, in fact, became a problem, to have him leave, because he was afraid of his own impulses. He was afraid he would rape women or would attack people on the street.

That had not been present prior to that particular event. He had never been, in fact, assaultive on any other occasion.

THE COURT: Let me ask you a question:

You testified previously that you felt that you were able to forecast with some reasonable medical certainty assaultive behavior so as to justify the utilization of seclusion; do I understand correctly?

THE WITNESS: Yes, Your Honor.

THE COURT: Well, the same standard having been applied to forcible medication, are you telling me in this instance that you were not correct in your assessment that there wasn't a reasonable probability of some sort of dangerous behavior?

Is that all you are telling me, really, or that you misdiagnosed the symptoms?

THE WITNESS: We may have misdiagnosed it but that is really not my opinion. I believe we were caught in this situation of being —

[65-94] THE COURT: I understand what you believe.

Now I am asking you whether or not you understood that you had the same authority to deal with forcible medication that you did with seclusion?

THE WITNESS: Yes, we did have that authority. Yes.

THE COURT: And you have told me that you felt that you have the credentials to predict dangerous behavior. That is why you feel that you can seclude, you may seclude prior to the actual sock on the jaw.

In other words, you told me that certain behavior triggers signals to the trained eye and that you can see the dangerous

behavior is inevitable, if not foreseeable, or is the foreseeable, if not the inevitable consequence of that initial signaling type behavior; true?

THE WITNESS: Yes, that is true.

THE COURT: Now, taking the same standard an applying the forcible medication, you were faced with a situation where you were observing this individual and, I take it, that what you are telling me is that on the basis of what you observed prior to him leaping into that fight, there was nothing that would have indicated to you that he was potentially dangerous?

[65-95] THE WITNESS: Well, it was iffy, your Honor. That is the difficulty.

THE COURT: You wouldn't seclude somebody on an iffy basis?

THE WITNESS: No.

THE COURT: You told me that those signals indicated to you a probability that it was okay to seclude.

You don't act on iffys, ever?

THE WITNESS: No. We would have acted if it was clear to us that this man was potentially violent. We would have acted.

THE COURT: So what you are saying is that the situation with this man prior to him somehow getting involved in this fight, injecting himself into the dispute between the attendant and the female patient, if that is what happened, you had no forewarning that he would take that kind of action, is that right?

THE WITNESS: That's correct.

THE COURT: Once you saw that he had the capacity to inflict physical harm on the attendant, you still failed to do anything, with the result that he got in another.

[65-96] THE WITNESS: Yes.

THE COURT: But you knew that you could make a medical judgment, yet you are telling me that on the facts that

you had, your medical judgment was that he was not dangerous enough to seclude.

THE WITNESS: Not dangerous enough, yes.

Q. Before the temporary restraining order, would you have forcibly medicated him when you believed there was the potential for violence even though you didn't believe there was a probability? A. Yes. Before the temporary restraining order he was, in fact, medicated in that manner because of our feeling that there was a probability of his becoming more disturbed and possibly violent.

Q. And you also testified, Doctor, about your ability to predict—

THE COURT: Did you use the same standard for seclusion and forcible medication prior to the restraining order?

THE WITNESS: No. We did not use the same standard for forcible medication prior to the restraining order.

THE COURT: In other words, you would need a clearer demonstration of potential danger before you would seclude than you would before you forcibly [65-97] medicated?

THE WITNESS: I'm getting a little lost, your Honor.

THE COURT: I will repeat the question:

You would look for a clearer demonstration of physical danger before you would seclude?

THE WITNESS: Yes.

THE COURT: Than you would require before you would say it was okay to forcibly medicate?

THE WITNESS: That is correct.

THE COURT: That is, prior to the restraining order?

THE WITNESS: Yes.

THE COURT: So it would take less apprehension for you to forcibly medicate than to seclude prior to the restraining order?

THE WITNESS: That is correct.

THE COURT: After the restraining order you felt that you were governed by the same standard?

THE WITNESS: Exactly.

Q. You also testified, Doctor, about your ability to predict whether or not one act would later lead to a serious threat of violence.

Do you believe you have that ability to predict for all patients or simply for some patients? [65-98] A. Well, I believe that that is for some patients who are patients known to us, and we know their histories, know essentially what has happened in the past, and also for patients who by history as it comes to us have been assaultive either in the community or at some time in the immediate past.

So you know the fact of their having been assaultive, so it's likely they will repeat that assaultive behavior.

THE COURT: Well, you had that in this case. You have one assault on an attendant prior to the second assault which caused this terrible injury to the fellow who had to leave and never come back; is that right?

THE WITNESS: Yes. But there were no assaults prior to the particular fight, and because there was provocation in that particular fight, it was felt that it did not really justify giving him forced medication at that point.

THE COURT: Provocation against the attendant?

THE WITNESS: No. No.

The attendant and another patient were involved in a scuffle, and the patient felt called upon — he was fond of the female patient, and [65-99] he felt called upon to intervene.

THE COURT: Forget about the reason he attacked an attendant.

THE WITNESS: Well, in his view, he was protecting a female.

THE COURT: Well, I suppose in the view of anybody who attacks an attendant, they feel that they're justified in that attack.

The question is the reasonableness of it and, I suppose, that goes to the mental stability of the person who is doing the attacking.

THE WITNESS: Yes.

THE COURT: So in this case, you had an attendant who had demonstrated a potential, at least, for attacking an attendant.

THE WITNESS: Yes.

THE COURT: And you just got through saying that if you had that sort of a demonstration, that might lead you to anticipate, because of your training, the necessity for forcible medication or something or seclusion in order to avoid a probable dangerous condition.

THE WITNESS: Yes.

Well, we certainly would have taken that action prior to the TRO.

[65-100] After the TRO, the decision was just that much more difficult and more complicated, and we were slower to make it. I think that is really what I am saying.

THE COURT: Well, you abdicated your responsibility? You and the medical profession choked on the problem?

THE WITNESS: We choked on the problem, yes. I don't think we abdicated our responsibility.

We were trying to follow our responsibility.

Q. What do you mean, Doctor, when you said you choked on the problem? A. The problem is it's a difficult decision at the best of times to take that kind of intervention, and there is an iffy situation, and you decide to do it this way or that way.

We decided to do it the way we did it, and it didn't work out. So we essentially made the wrong decision.

I mean, by history it was the wrong decision. At the time it seemed the right decision.

It was wrong because it resulted in a more violent attack on somebody else and somebody else was hurt.

So we were wrong.

[65-101] Q. Let me ask you, Doctor: Were there clinical reasons for not seeking a guardian for J.T. when he was refusing his medication?

THE COURT: You make the same diagnosis, the same prescription for people, regardless of the consequences, don't you?

Either the diagnosis is accurate and the prescription is called for or it's not, regardless of whether Judge Tauro is looking over your shoulder or he isn't?

You don't have two standards, one when a judge is looking at you? You have professional standards that you keep?

THE WITNESS: Yes, your Honor; but the professional standards prior to the temporary restraining order, as I understand it, our standards were to medicate in psychiatric emergencies, and we were unable to do that.

After the temporary restraining order, we could not medicate in psychiatric emergencies, but could medicate only in physical emergencies.

THE COURT: Well, it all depends on what you consider to be a psychiatric emergency.

Did you feel that somebody had to actually slug somebody in the jaw before you could?

[65-102] THE WITNESS: That was the tendency, your Honor, yes.

THE COURT: Okay.

I see everybody nodding up and down like that, but that doesn't impress me one bit, all the nodding.

Okay.

Q. Let me ask you again, Doctor: Were there any clinical reasons for not seeking a guardianship for J.T. when he was refusing his medication? A. Yes. The clinical reasons were that he had a great deal of conflict with his mother, and the mother was very involved in his care and management.

He was resentful of her involvement and essentially wanted her to keep away.

His mother wanted to become his guardian and, again, there was a problem with regard to having her become his guardian.

I had spent considerable time and effort working with both the patient and his mother to have the mother relinquish some of her caring for her son. As he grew into his twenties, he had something left from his grandfather's estate, some monies and stocks and so on, and his mother sort of held those for him and would not give them over into his care.

[65-103] There was a great conflict between the two of them on this account, and to then have her become his guardian, I think, would have really reversed a lot of therapeutic work that had already been accomplished.

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G. Selected Portions of Transcript of Trial, January 18, 1979
(Testimony of Michael Gill, M.D.)

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[66-43] Q. Now, Doctor, I'd like to call your attention to the patient JT, whom you testified the other day twice assaulted staff, causing injuries, when he was not forcibly medicated.

The Judge asked you if you, quote, choked in not medicating JT before the second staff was assaulted.

You responded that you may have choked.

Have you ever used the term "choked" in your own vocabulary before the Judge asked the above question?

THE COURT: Oh, come on.

A. No. I used it in a literal sense, not, I think, in the sense that the Judge meant it.

[66-44] THE COURT: Okay, Now hold it.

You want to tell me that you didn't know what I meant when I asked you that question?

THE WITNESS: That is correct, your Honor.

THE COURT: You thought that I meant that you physically gagged?

THE WITNESS: No. I don't mean that. I really didn't understand what you meant by the term.

I understood that the term was that I had difficulty with the decision, and that is correct. I had difficulty with the decision.

THE COURT: You had difficulty acting? You were immobilized?

THE WITNESS: I wasn't immobilized. I made a decision.

In retrospect, I believe it was the wrong decision, but I made a decision.

And when I am asked if I choked on the decision, I don't know.

THE COURT: You made a decision which was contrary to what you thought was in the best interests of your patient? You made a decision not to medicate?

THE WITNESS: No. That is — well, I made a decision not to medicate, yes, but that was within the confines of the temporary restraining order, that [66-45] we were not to medicate unless there was a situation that was comparable to a situation meriting seclusion. And this situation, in my opinion at that time, was a single episode of violence that did not constitute that kind of — it was not an ongoing situation of violence.

He had no history of violence. He had never attacked anybody before, and it was not clear that it was going to go on. We thought that once was probably the end of it. That was all there was to it.

And I made a decision then that JT is not going to do that again with my psychotherapy which was going on actively at the time and with the interventions from other staff and with all the attention that was being paid to him, that that would be sufficient to prevent any further outbreak.

I was wrong in retrospect.

THE COURT: Okay. You made that decision and, I take it, that was a medical judgment that you made, is that right?

THE WITNESS: Well, it was.

THE COURT: It was a medical judgment?

THE WITNESS: It had to be a medical judgment, but it

was a medical judgment under the terms of the restraining order, which, I think, altered my [66-46] medical judgment.

THE COURT: Do you mean to tell me that extraneous factors could dictate to you whether or not there was a likelihood that this fellow was going to repeat the violent act?

Is that what you want me to believe here today?

You just got through telling me that you formed a judgment that this was a single episode and that the single episode of violence would not be repeated, not with your psychotherapy and not with the intervention of others. You made that judgment that it would not be repeated, and it was just going to be a single act.

Do you mean to tell me that the temporary restraining order had something to do with you forming a judgment as to whether or not that fellow was likely to repeat the violent act?

THE WITNESS: I had formed a judgment, your Honor—

THE COURT: Do you understand the question? I want a specific answer to my question.

THE WITNESS: I am trying to.

THE COURT: Listen to it: Are you telling me that the temporary restraining order caused you to [66-47] come up with a judgment one way or the other as to whether or not that man was likely to repeat — you told me that you made the judgment that he was not likely to repeat the violence.

THE WITNESS: That's correct.

THE COURT: Now, that judgment is independent. Don't you make that judgment independent of any temporary restraining order?

THE WITNESS: Yes.

Q. Is it your opinion that the temporary restraining order required you to ask the question of whether or not there would be a serious threat of personal injury before you could forcibly medicate? A. The temporary restraining order prevented me from making a clinical decision that would allow me to give him medication when there was not an obvious threat of violence. That is really what I am trying to get at.

Q. Let me stop you.

Doctor, did you make a clinical judgment at the point after the first assault that there was a psychiatric emergency at that point for JT?

After the first assault by JT, is it your belief that JT was in a state of psychiatric emergency? A. I believe before the first assault that JT was in a state of psychiatric emergency. Before the first [66-48] assault.

Q. If you had understood that it was your legal right to forcibly medicate an individual who was in a state of psychiatric emergency based upon your clinical judgment, would you have forcibly medicated JT either before or after the first assault? A. I believe that — I'm sorry. I have forgotten the wording of your question.

Q. If you had believed that it was your legal right to forcibly or involuntarily medicate JT when he was in a state of psychiatric emergency, would you have forcibly or involuntarily medicated him either before or after his first assault? A. Yes. If I believed it was my legal right to do so, I would have done so.

Q. Do you have an opinion whether JT ever would have assaulted any staff member if you could have medicated him when you first believed there was a psychiatric emergency but did not yet believe his behavior posed a serious threat of personal injury of the type that would justify seclusion? A. From the patient's history and my knowledge of him over a number of years and from frequent similar states that he was in on hospitalization, I have the opinion, yes, that if he were medicated while in a [66-49] state of psychiatric emergency, it would have prevented the outbreak of violence.

THE COURT: You just got through telling me that this fellow's history was negative with respect to any indications of violence.

THE WITNESS: That's correct, your Honor. That is because he was treated with involuntary medication each

previous admission. He was told he had to take his medication, and he took it, and within a very short time he was calmer and he was less psychotic. He was essentially getting over his acute episode.

THE COURT: That was your judgment, that the only reason he wasn't potentially violent was because he had been forcibly medicated?

THE WITNESS: Well, that is in hindsight. Easy to see it in hindsight. I didn't know that at the time.

THE COURT: At the time you were faced with a patient and you had to make some medical judgments, didn't you?

THE WITNESS: I am talking about the earlier hospitalizations, your Honor. During those times we did what was the standard psychiatric practice of giving him medication.

[66-50] THE COURT: You just got through telling me before that you didn't think you were unable to predict that he would have a second episode of violence because his history was negative for violence and you thought that the single episode, where he intervened in that fight with the woman patient, was going to be just that, a single episode and not likely to be repeated because of your psychotherapy and the intervention of others; is that a fair summary of your testimony?

THE WITNESS: We hoped that that would be true, yes.

THE COURT: That was your judgment? That was your medical decision, wasn't it?

THE WITNESS: Yes.

THE COURT: If you made a medical decision the other way, if you said, "Look, this guy is going to bop the next guard that comes down the hall," then you would have felt that you could have forcibly medicated him, right?

THE WITNESS: Yes.

THE COURT: So you made the threshold judgment that there was not likely to be a repetition?

THE WITNESS: Yes, your Honor.

THE COURT: That is what you told me, isn't it?

[66-51] THE WITNESS: Yes, your Honor.

THE COURT: And you made that because you were familiar with the man's history, right?

That is what you told me, right?

THE WITNESS: I was familiar with the man's history in terms of his getting medication for his psychiatric condition.

The issue of violence—

THE COURT: You didn't just read lines in the history. You had the man's folder before you, didn't you?

THE WITNESS: Well, I was involved in the other hospitalization, so I knew it from personal contact with him.

THE COURT: Well, then you were personally familiar with the history?

THE WITNESS: Yes.

THE COURT: So you didn't have to read it again.

THE WITNESS: Exactly.

THE COURT: Okay. Now having in mind your personal awareness that he had been medicated before and, therefore, not violent, you, even knowing that he had been personally medicated before, that didn't deter you from the opinion that you made that this was [66-52] going to be a single episode of violence, even though he was not being forcibly medicated?

THE WITNESS: Your Honor, he was not forcibly or involuntarily medicated prior to this because of threats of violence.

He was medicated because of his psychiatric condition.

THE COURT: Regardless. I am saying: You knew that before he had been forcibly medicated; you knew that now he was not being forcibly medicated; and you knew that he had a violent episode.

Now, given all that, you still formed the medical judgment that that was a likely single episode and not likely to occur again because of your psychotherapy and the intervention of others; isn't that right?

THE WITNESS: But my medical judgment—

THE COURT: Is that right?

THE WITNESS: Well, that is not correct, your Honor.

THE COURT: Where is it incorrect?

THE WITNESS: My medical judgment was that the patient needed medication when he first came to the hospital.

THE COURT: But we are not talking about [66-53] medication now. We are talking about your judgment as to whether he was likely to repeat the act of violence.

You made a judgment that he was not likely to repeat the act of violence; isn't that right?

THE WITNESS: That's correct, yes.

THE COURT: And you made that fully aware of the fact that on his prior admissions, he had been forcibly medicated?

THE WITNESS: Yes, but forcibly medicated for a psychiatric condition, not for violence.

THE COURT: I didn't say for what reason, did I?

I just said that he had been forcibly medicated, right?

THE WITNESS: Yes.

THE COURT: With the consequence that there had been no violence?

THE WITNESS: With the consequence that he got over his psychiatric condition.

THE COURT: With the consequence that there was no history of violence?

THE WITNESS: There was no history of violence, but I don't know how much that was a consequence of his being treated or not.

[66-54] I suspect it was involved in it, but we were more concerned with his psychiatric condition than with violence.

THE COURT: Are you now saying that you don't think that the fact that he was forcibly medicated before in any way acted as a deterrent to his violence?

THE WITNESS: At the time I did not know that. That was—

THE COURT: I am asking you now.

THE WITNESS: Now, with hindsight, yes, I think it did deter him from violence.

THE COURT: Before?

THE WITNESS: Before.

THE COURT: But given all that, given all the information you had, you made a judgment that he was not likely to repeat that act of violence?

THE WITNESS: Yes.

THE COURT: Okay. That was a medical judgment, right?

THE WITNESS: Yes.

THE COURT: That had nothing to do with the restraining order, did it, that medical judgment as to whether he was likely to repeat the act of violence?

Now that is the specific question I am [66-55] focusing on.

THE WITNESS: My medical judgment at that time, I think, would have to be that.

THE COURT: I am not asking you to reconstruct it.

I am saying to you: You made a medical judgment that he was not likely to repeat the act of violence.

Now, you have told me that before, haven't you?

THE WITNESS: Yes.

THE COURT: Now, that medical judgment had nothing to do with the restraining order?

THE WITNESS: Well, your Honor, you separate out the judgment of violence from his clinical state. The two go hand in hand.

It's very difficult for me to separate them out.

THE COURT: Look, Doctor, I don't care if we stay here 65 more days, you are going to give me a straight answer to this question. You are not going to give me the answer I want to hear because I don't care what your answer is.

You are going to give me a responsive answer and not a speech.

[66-56] THE WITNESS: I am trying to give a responsive answer, your Honor, but I want it to be—

THE COURT: Let's start again.

THE WITNESS: — as truthful as I can.

THE COURT: I know you want to be truthful, but I want you to be precise.

Now, you said that you made a medical judgment that this man was not likely to repeat the act of violence, isn't that right?

THE WITNESS: Correct.

THE COURT: Now, when you make a medical judgment, don't tell me that you make a medical judgment on the basis of whether there is a temporary restraining order outstanding.

You don't want to tell me that, do you?

THE WITNESS: No, I don't.

THE COURT: Now, if you had made a medical judgment that he was likely to repeat, then even you, as concerned as you were about the temporary restraining order, would have forcibly medicated him, right?

THE WITNESS: Yes. That is correct.

THE COURT: So the only reason you didn't forcibly medicate him was because you made the medical judgment that he was not likely to repeat the act of violence; isn't that right?

[66-57] THE WITNESS: I have trouble saying "the only reason."

THE COURT: Sure, you have trouble, but the—

THE WITNESS: It wasn't the only reason, no, your Honor. It was not the only reason.

THE COURT: All right. Go ahead. Ask him some questions.

Q. Doctor, did the fact that you had to ask yourself the question whether there was a likelihood that he was going to repeat the act of violence have anything to do with the temporary restraining order? A. Yes, that was a factor.

I mean, the fact is that in making a medical judgment, you make a medical judgment in the absence of a threat of contempt of court.

I mean, that makes a whale of a difference, and I think that that is what I am trying to get at: That influences one's medical decisions. Whether we like it or not, it influences our medical decisions.

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H. TRANSCRIPT OF HEARING OF DECEMBER 18, 1980
(SEE *App. to Pet. for Cert.*, pp. 166a-180a)

IX. RELEVANT PROPOSED FINDINGS OF FACT FILED WITH DISTRICT COURT

A. Symbols for Reading Plaintiffs' Proposed Findings
B. List of Full Titles of Medical Texts Cited in Plaintiffs' Proposed Findings
C. Medication

1. *Plaintiffs' Proposed Findings of Fact and Defendants' Rebuttal*
2. *Defendants' Proposed Findings of Fact and Plaintiffs' Rebuttal*
3. *Defendants' Rebuttal of Anticipated Plaintiffs' Rebuttal*

D. Betty Bybel
E. Rubie Rogers

A. Symbols Used in the Plaintiffs' Brief and Findings

The following are the symbols being used by the Plaintiffs in their brief and findings:

1. *All Plaintiffs' and Defendants'* names are in capital letters and italicized, with a P or a D before the name, depending on whether they are a Plaintiff or Defendant. The following is an example:

P—*WADSWORTH*—(A Plaintiff)
D—*GILL*—(A Defendant)

2. *All Plaintiffs and defendants Witnesses* have a P or a D before their name respectively. Non-party witness names are neither capitalized nor italicized. For example:

P—Keller—(A Plaintiffs' Witness)
D—Crane—(A Defendants' Witness)

3. Before all of the *Plaintiffs' Hospital Records* we have Doc. No. or Doc. Nos. For example:

Doc. Nos. 400026, 400146

4. For all *Citations to the Trial Transcript* it will say TR. before the book and page number. For example:

P—Rundle TR. 30-31, lines 5-13

This cite means Plaintiffs rely on: Dr. Rundle, a Plaintiffs' witness, at the 30th. book, 31st. page, lines 5-13, for the proposed finding or for the above proposition.

5. For *Stipulations made prior to the trial*, the brief will indicate either:

Stip. or Stipulation at p. A92

The A indicates the Stipulation was made prior to trial and was provided to the Court prior to the trial. For example:

Stip. No. 4, p. A112

6. For a *Stipulation from the Bench Book*, filed with the brief and proposed findings of both parties, it will say, for example:

Stip. or Stipulations, p. 42

There will be no A before the page number.

7. For all *Learned Treatise* if a P proceeds the article it was an article introduced by Plaintiffs, a D for an article introduced by Defendants. Only a shortened title of the article or book will be given in the cite. All articles have quotation marks around the name or title given. For example:

P—"Lichtenberg"

D—"Davis and Cole"

If an article introduced by Plaintiffs' counsel was introduced through a defense witness or Defendant it will often so indicate. For example:

P—"Baldessarini, Lipinisky" (Introduced through
D—*KANTAR* TR. 11-14, lines 14-18.)

B. List of Full Titles of Medical Texts Cited by Plaintiffs in Their Findings.

Medical Texts

1. American Psychiatric Association, "Position Statement on the Right to Adequate Care and Treatment for the Mentally Ill and Mentally Retarded," in 134 *Amer. J. of Psychiat.* (March, 1977).

2. Balessarini, Lipinski, "Risks and Benefits of Antipsychotic Drugs," 298 *New England J. of Medicine*, 427 (1973).

3. Barton, Dr. Walter E., "Administration in Psychiatry," Thomas Pub. Co. (1962).

4. Bettelheim, Bruno, *Home for the Heart* (1974).

5. Bochoven and Solomon, "Comparison of Two Five Year Follow-Up Studies, 1947 to 1952 and 1967 to 1972," 132 *Amer. J. of Psychiat.* (August, 1975).

6. Carpenter, McGlashan, Strauss, "Treatment of Acute Schizophrenia Without Drugs: An Investigation of Some Current Assumptions," 134 *Amer. J. Psychiat.* (August, 1975).

7. Cole, J. and Davis, J. "Chapter on Antipsychotic Drugs," reprinted in Freedman and Kaplan, eds., *Comprehensive Textbook of Psychiatry*, (1975).

8. Crane, "Clinical Psychopharmacology in its 20th Year," *Science* (July, 1973).

9. Crane, "Two Decades of Psychopharamcology and Community Mental Health: Old and New Problems of the Schizophrenic Patient," *Transactions of the NY Acad. of Sci.*, Series II, Vol. 36 (1974).

10. DiMascio, "Behavioral Toxicity," *The Clinical Handbook of Psychopharmacology*, DiMascio and Shader, ed. (Science House, NY, 1970).

11. DiMascio, Giller, Shader, "Behavioral Toxicity of Psychotropic Drugs: III Effects on Perceptual and Causative Functions; IV Effects on Emotional (Mood) States," *Connecticut Medicine* (Oct., 1968).

12. DiMascio, Shader, Harmatz, "Behaviorial Toxicity of Psychotropic Drugs: V. Effects on Gross Behavior Patterns," *Connecticut Medicine*, Vol. 33, No. 4 (April, 1969).

13. Gardos, Cole, "Maintenance Antipsychotic Therapy: Is the Cure Worse than the Disease," 133 *Amer. J. Of Psychiat.*, 1 (January, 1976).

14. Gair, D., Bullard, D., Corwin, J., "Seclusion of Children as a Therapeutic Ward Practice," *American Journal of Ortho-Psychiatry* (1965).

15. Goodman and Gilman, *Pharmacological Basis of Therapeutics*, 5th ed. (1975).

16. Greenblatt, Shader, DiMascio, "Extrapyramidal Side Effects of Psychotropic Drugs," *Connecticut Medicine*, Vol. 33, No. 3 (March, 1969).

17. Gutheil, Thomas, "Observations on the Theoretical Bases for Seclusion of the Psychiatric Inpatient," *Amer. J. of Psychiat.* (March, 1978).

18. Halleck, "Legal and Ethical Aspects of Behavior Control," 131 *Amer. J. of Psychiat.*, 381 (April, 1974).

19. Hollister and Ayd, "Polypharmacy in Psychiatry: Is it Necessary, Good or Bad?", *Regional Psychopharmaco*—Therapy and the Right to Treatment (1974).

20. Klawans, Rubovitz, "Effects of Cholinergics and Anti-Cholinergic Agents on Tardive Dyskinesia," 37 *J. Neur., Neurosurgery and Psychiat.*, 941 (1974).

21. Klawans, "The Pharmacology of Tardive Dyskinesia," 130 *Amer. J. of Psychiat.*, 82 (1973).

22. Klerman, "Psychotropic Drugs as Therapeutic Agents," presented at *Conference on Control of Behavior Through Drugs* (1972).

23. Ludwig, Symposium, "Active Treatment of the Chronic Schizophrenic," *U.S. Government Printing Office*, #0-544-464-719 (1974).

24. Mendel, W., "Tranquilizer Prescribing as a Function of the Experience and Availability of the Therapist," *American Journal of Psychiatry* (July, 1967).

25. Menolascino and Mason, "The Right to Treatment for Mentally Retarded Citizens," *Creighton Law Review*, 159 (10/1/76).

26. Menolascino, "Three Frequent Types of Behavioral Disturbances in Institutionalized Retardates," *British Journal of Mental Sub-Normality* 71 (1972).

27. Menolascino, "Psychiatry's Past, Current, and Future Role," *Psychiatric Approaches to Mental Retardation* [PAMR] (1970).

28. Klawans, "Neurological Syndromes Associated With Antipsychotic Drug Use—A Special Report," 28 *Arch. Gen. Psychiat.*, 463 (April, 1973).

29. Paul, Tobias, Holly, "Maintenance Antipsychotic Drugs in the Presence of Active Treatment Programs," *Archives of General Psychiatry* (July, 1972).

30. Prien and Caffey, "Guidelines for Antipsychotic Drug Use," *The Veterans Administration Central Neuropsychiatric Research Laboratory, Research Report No. 95* (May, 1974).

31. Prien, "Symposium, Active Treatment of Chronic Schizophrenic," *U.S. Government Printing Office* (1974).

32. Raskin, D., "Akathisia: A Side Effect To Be Remembered," *American Journal of Psychiatry*, Vol. 129:3 (Sept., 1972) (quoting Frank Ayd).

33. Schmidt and Jacob, "Persistent Dyskinesias Following Phenothiazine Therapy," *Archives of Neurology*, Vol. 14 (1966).

34. Sovner, DiMascio, Berkowitz, Randolph, "Tardive Dyskinesia and Informed Consent," *Psychosomatics*, Vol. 19, No. 3 (March, 1978).

35. Van Putten, Crumpton, Yale, "Drug Refusal in Schizophrenia and the Wish to be Crazy," 33 *Arch. of Gen. Psychiat.*, 1443 (December, 1976).

36. Van Putten, "Why Do Schizophrenic Patients Refuse to Take Their Drugs," 31 *Arch. of Gen. Psychiat.* (July, 1974).

37. Van Putten and May, "Subjective Response as a Predictor of Outcome in Pharmacotherapy: The Consumer Has a Point," 35 *Arch. of Gen. Psychiat.*

38. White, "Time Out Duration and the Suppression of Deviant Behavior in Children," *Journal of Applied Behavior Analysis* (1972).

C. Medication

1. Plaintiff's Proposed Findings of Fact and Defendants' Rebuttal*

THE PLAINTIFF CLASS' CLAIM FOR INJUNCTIVE RELIEF CONCERNING THE INVOLUNTARY ADMINISTRATION OF MEDICATION AND GENERAL MEDICATION FINDINGS FOR LIABILITY AND DAMAGES

(I.) *Introduction to Antipsychotic Medication*

1.) Antipsychotic medications are chemical agents used to manage and treat psychosis. They are also called neuroleptic drugs. (D.—*SZLYK* TR. 6-4, lines 4-7; 6-5, lines 13-16.)

2.) There are five generic classes of chemical agents that are antipsychotic agents. Two classes are the phenothiazines and butyrophenones. (D—*SZLYK* TR. 6-4, lines 7-9, 22-25; 6-5, lines 1-12; D-Brill TR. 57-25, lines 19-25.)

3.) Thorazine and Mellaril are both antipsychotic drugs and are both phenothiazines. (D—*SZLYK* TR. 6-4; lines 12-15; 6-5, lines 11-12.)

4.) Haldol is an antipsychotic drug in the butyrophenones class. (D—*SZLYK* TR. 6-4, lines 10-11; 6-5, lines 8-10).

5.) In general terms, the drugs influence the chemical transmissions in the brain. The drugs may effect both the excitatory functions and the inhibitory functions in the brain. (D—Brill TR. 57-24, lines 6-9.)

6.) Antipsychotic drugs metabolize slowly and are stored in body tissues. The drugs are long-acting drugs and are only slowly released from the body when the doctor discontinues the medication. The drugs remain in the body tissues for quite some time. (P—DiMascio TR. 29-21, lines 7-13.)

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* Defendants' Rebuttals are designated "DR".

7.) Similarities in effects among the five classes of antipsychotic compounds are far greater than their differences. (Stipulations, p. 5; Statement of Agreed Facts #16.)

8.) Similarities in effects of phenothiazines are so great that generalizations can encompass the whole group. (Stipulations, p. 5; Statement of Agreed Facts #17.)

9.) The similarities of the antipsychotic drugs are greater than the differences, but there are significant differences. (D—Brill TR. 57-25, lines 19-26; 57-26, lines 1-3.)

10.) Doctors have ordered or authorized the administration of the following medications as part of a patient's planned therapeutic program.

(a) Thorazine
(b) Mellaril
(c) Haldol
(d) Stelazine
(e) Lithium Carbonate
(f) Navane
(g) Sparine
(h) Permitil
(i) Chloral Hydrate
(j) Moban
(k) Compazine
(l) Serentil
(m) Prolixin
(n) Prolixin Decanoate
(o) Prolixin Enanthate
(p) Sodium Amytal
(q) Desipramine
(r) Imipramine
(s) Protriptyline
(t) Cogentin
(u) Artane
(v) Northriptyline
(w) Amitriptyline (Elavil)

(Stipulations, Statement of Agreed Facts #25, at page 354.)

11.) Doctors have issued PRN medication orders, for the following medications:

(a) Thorazine
(b) Mellaril
(c) Haldol
(d) Stelazine
(e) Prolixin
(f) Sodium Amytal
(g) Navane
(h) Sparine
(i) Permitil
(j) Cogentin
(k) Artane
(l) Moban
(m) Compazine
(n) Serentil

(Stipulations, Statement of Agreed Facts #26, at page 354, 355.)

12.) Physicians have prescribed each of the following medications to patients with each of the following diagnoses:

(a) *Character disorder*

1. Thorazine
2. Mellaril
3. Haldol
4. Stelazine
5. Sodium amytal
6. Northriptyline
7. Amitriptyline
8. Desipramine
9. Imipramine
10. Protriptyline
11. Cogentin
12. Artane
13. Elavil
14. Chloral Hydrate
15. Serentil

(b) *Schizophrenia*

1. Prolixin
2. Lithium Carbonate
3. Navane
4. Prolixin Decanoate
5. Prolixin Enanthate
6. Permitil
7. Moban
8. Thorazine
9. Mellaril
10. Haldol
11. Stelazine
12. Sodium amytal
13. Northriptyline
14. Amitriptyline
15. Desipramine
16. Imipramine
17. Protriptyline
18. Cogentin
19. Artane
20. Elavil
21. Chloral Hydrate
22. Serentil

(c) *Manic-depression*

1. Prolixin
2. Lithium Carbonate
3. Navine
4. Thorazine
5. Mellaril
6. Haldol
7. Stelazine
8. Sodium amytal
9. Northriptyline
10. Amitriptyline
11. Desipramine
12. Imipramine
13. Protriptyline
14. Cogentin
15. Artane
16. Elavil
17. Chloral Hydrate
18. Serentil

(d) *Mental retardation*

1. Prolixin
2. Navane
3. Thorazine
4. Mellaril
5. Haldol
6. Stelazine
7. Sodium amytal
8. Northriptyline
9. Amitriptyline
10. Desipramine
11. Imipramine
12. Protriptyline
13. Cogentin
14. Artane
15. Elavil
16. Chloral Hydrate
17. Serentil

(e) *Psychosis*

1. Prolixin
2. Lithium Carbonate
3. Prolixin Decanoate
4. Prolixin Enanthate
5. Permitil
6. Moban
7. Navane
8. Thorazine
9. Mellaril
10. Haldol
11. Sodium amytal
12. Northriptyline
13. Amitriptyline
14. Desipramine
15. Imipramine
16. Protriptyline
17. Cogentin
18. Artane
19. Elavil
20. Chloral Hydrate
21. Serentil

(Stipulations, Statement of Agreed Facts, #27, at page 345, 356.)

(II.) *Adverse Effects Caused by Antipsychotic Medications*

13.) The side effects of antipsychotic medication are due to anatomically localized effects in the brain. It appears that the drugs interfere with the metabolism of the chemical transmission, the metabolism of the chemical transition in certain key locations in the other parts of the brain, thereby causing the side effects. (D—Brill TR. 57-20, lines 11-16.)

(A.) *Tardive Dyskinesia*

14.) Tardive dyskinesia is a neurological syndrome which is a late appearing consequence of antipsychotic drug treatment. Its overt symptoms include involuntary motor movements, particularly of the face, lips, tongue, in which a variety of sucking and grimacing movements occur regularly that cannot be controlled by the patient. There can also be involuntary movement of the fingers and hands, the legs and the pelvic area. In addition, there is a phenomena where the tongue starts pushing against the side of the mouth. It is called "fly catcher tongue" because it looks like a frog catching flies. The state full blown can interfere with swallowing and can affect all motor activity, including those interfering with purposeful movements of the arms and legs. (P—Kauff TR. 18-117, lines 23-25. P—Dimascio TR. 29-21, lines 23-25; 29-22, lines 16-19. P—"Goodman and Gillman" TR 13-112, lines 22-23. D—*KANTAR* TR. 13-112, lines 9-25; 13-112, lines 1-4. D—*SZLYK* TR. 6-12, lines 12-22.)

DR-14.) Dr. Brill testified that tardive dyskinesia may run anywhere from 10 to 30 percent in long term cases, but that it occurs almost entirely only in cases that have had treatment for several years. Tr. 57 at 87 (Brill). Tardive dyskinesia can be, but is not necessarily, a late appearing consequence of antipsychotic drug treatment. See Plaintiffs' Proposed Finding (Medication—General), ¶36.

15.) Fibrillation of the tongue is a significant warning sign that a patient has tardive dyskinesia. (D—"Kobayashi", P—Kauff TR. 20-31, lines 11-20.)

16.) Tardive dyskinesia is often irreversible. The abnormal movements may persist indefinitely after neuroleptic drug therapy is discontinued, and there is no generally effective treatment for irreversible dyskinesias. (Plaintiffs Exhibit ¶31, at page 173; P—"Freedman and Kaplan" TR. 13-130, lines 12-14; 13-131, lines 20-25. D—*KANTAR*, P—"Baldessarini and Lipinski" TR. 13-117, lines 17-25; 13-118, lines 4-6.

P—"Crane—Risks" TR. 61-20, lines 19-21; 61-21, lines 23-25; 61-22, lines 1-2. P—"Klawans" TR. 20-37, lines 12-14. P—Kauff TR. 18-118, lines 12-14.)

17.) Tardive dyskinesia may result in frank physical impairment, especially if it involves the limbs, trunks or pharyngeal musculatures. When it is not physically disabling, it can be psychologically disabling. In mild cases, tardive dyskinesia can be a source of embarrassment, and, in severe cases, suicide may ensue. (Plaintiffs Exhibit #31, at page 173; P—"Crane—Two Decades" TR. 20-35, lines, 15-22. P—Kauff TR. 20-35, lines 8—24. D—*KANTAR* TR. 13-108, lines 18-25; 13-109, lines 13-23.)

DR-17.) Despite the risks of tardive dyskinesia and other side effects, Dr. Crane uses antipsychotic medication in his practice. Tr. 61 at 35-36 (Brill).

18.) If a patient has tardive dyskinesia it can be extremely detrimental to their self image and self esteem and affect their ability to reintegrate into the community. (D—*KANTAR* TR. 13-108, lines 18-25; 13-109, lines 13-23.)

19.) Because of their bizarre appearance, patients suffering from tardive dyskinesia stand out even in a mental hospital. For individuals who live in the community, it may be a source of considerable embarrassment and thus may aggravate an already precarious adjustment. (P—"Crane—Two Decades" TR. 20-35, lines 15-22. P—Kauff, TR. 20-35, lines 8-24. D—*KANTAR* TR. 13-108, lines 18-25; 13-109, lines 13-23; Plaintiffs Exhibit #31, at page 173.)

20.) Tardive dyskinesia is the outcome of a complex patient-drug interaction as yet not well understood. (Plaintiffs Exhibit #31, page 177.)

DR-20 & 21.) The reasons antipsychotic drugs cause side effects are understood, as the side effects are due to anatomically localized effects in the brain. Tr. 57 at 20-21 (Brill).

21.) The medical profession has only a hypothesis concerning the cause of the syndrome tardive dyskinesia. (D—*KANTAR*

TR. 13-117, 118, 119. P—"Baldessarini and Lipinski" TR. 13-117, lines 17-25; 13-118, lines 10-11.)

Dr-21.) The Baldessarini and Lipinski article does not state that the medical profession has only a hypothesis concerning the cause of tardive dyskinesia. Rather it states that the hypotheses concerning the cause have been adequately reviewed. Dr. Kantar is cited only because he recognized the article as authoritative. Tr. 13 at 117-119 (Kantar).

22.) The elderly, brain damaged and females all appear more likely than others to develop the syndrome. (P—Kauff TR. 18-118, lines 24-25; 18-119, lines 1-2. D—*KANTAR*; P—"Goodman and Gillman" TR. 13-112, lines 9-25; 13-112A, lines 1-4. D—"Klawans"; P—Kauff TR. 20-29, lines 21-25; 20-30, line 1. P—DiMascio TR. 29-23, lines 19-25).

DR-22.) Studies taking into account the characteristics of patient population and risk have suggested female sex is not correlated with the development of tardive dyskinesia. Tr. 19 at 67 (Kauff).

23.) No age group is immune to tardive dyskinesia. A condition resembling tardive dyskinesia and lasting for several months was described in young children and teenagers. (P—"Crane—Two Decades"; P—Kauff TR. 20-35, lines, 8-12; 20-36, lines 8-14.)

DR-23.) "To date, complete recovery [from tardive dyskinesia] has been the rule in children, and although there is less information available, recovery appears to be more likely in young adults as well." Tarsy & Baldessarini, "The Tardive Dyskinesia Syndrome", in Klawans, H.L., *Clinical Neuropharmacology*, Vol. 1 (1976), pp. 31-32.

24.) Any patient taking neuroleptic drugs is potentially at risk to develop tardive dyskinesia. (Plaintiffs Exhibit #31, page 173.)

DR-24.) Sovner, DiMascio, Berkowitz and Randolph, although cited for the proposition that any patient taking neuroleptic drugs is potentially at risk to develop tardive

dyskinesia, state more precisely that although any patient is at risk of developing tardive dyskinesia, only patients who have received neuroleptic drug therapy continuously for one year or more are at serious risk. Pl. Ex. 31, p. 173.

25.) No class of antipsychotic drug appears to be free of risk. (P—"Baldessarini and Lipinski"; D—*KANTAR* TR. 13-118. lines 6-7.)

26.) Patients receiving antipsychotic drugs for over a year are considered at high risk to develop tardive dyskinesia, although tardive dyskinesia has developed after only months of treatment. (Plaintiffs Exhibit 31, page 173.)

27.) Tardive dyskinesia usually begins following a minimum of three months of exposure to antipsychotic drugs. (D—"Marsden, Tarsy, Baldessarini" TR. 61-11.)

28.) The use of phenothiazines in high doses over long periods of time make the syndrome likely, as does the practice of polypharmacy; prescribing two drugs concomitantly, and the introduction of antiparkinsonian agents over long periods of time. (P—Kauff TR. 18-119, lines 3-9. P—Dimascio TR. 29-24, lines 4-21.)

DR-28.) The co-administration of antiparkinsonian drugs with tranquilizers does not increase the later development of tardive dyskinesia. Tr. at 17 (Tarsy). The simultaneous administration of an antiparkinsonian drug and an antipsychotic drug does not increase the likelihood that existing tardive dyskinesia will become irreversible. Tr. at 17 (Tarsy). See Defendants' Proposed Finding F-270 for evidence that polypharmacy does not increase the likelihood of tardive dyskinesia or its becoming irreversible.

29.) Once a patient has symptoms of tardive dyskinesia, continued drug therapy may exacerbate the severity of the abnormal movements or cause them to become irreversible. (Plaintiffs Exhibit #31, "Sovner, DiMascio, Berkowitz, and Randolph" at page 173.)

30.) When tardive dyskinesia is first finally recognized, antipsychotic drugs should be discontinued and subsequent treatment should be oriented around nondrug methods. (D—"Kobayashi" TR. 20-31, lines 21-25; 20-33, lines 10-12; 20-32; lines 21-24. P—Kauff TR. 20-31, lines 21-25; 20-33, lines 10-15.)

31.) Anticholinergic drugs (anti-parkinson drugs) given to prevent pseudo Parkinsonian side effects may worsen dyskinesia and should be discontinued at the first sign of dyskinesia. (D—"Kobayashi" TR. 20-31, lines, 21-25; 20-33, lines 16-23. P—Kauff TR. 20-31, lines, 21-25; 20-33, lines 16-23; 20-33, lines 24-25, 20-34, line 1.)

32.) The very treatment that causes tardive dyskinesia can also mask its clinical manifestations. Often, the early signs go undetected because the abnormal movements have been suppressed by the drug therapy even though the underlying pathophysiological processes have been present for several years. In view of recent reports indicating that not all cases of drug-induced dyskinesia are irreversible and that early detection and withdrawal are the significant factors determining the reversibility, it is important to realize that by the time of diagnosis, the syndrome may have already progressed to the irreversible stage. Plaintiffs Exhibit #31, at page 173. (P—Kauff, TR. 18-119, lines 17-22.)

33.) Should it be necessary to reinstitute treatment of the offending drug, or increase the dosage of the offending drug, or switch to a different antipsychotic agent, the syndrome may be masked. (D—"Klawans" TR. 20-29, lines 2-11. D—"Kobayashi" TR. 20-31, lines 21-25; 20-34, lines 3-13. P—Kauff TR. 20-31, lines 21-25; 20-34, lines 3-18).

34.) Drug holidays in patients receiving long-term medication are advised for the following reasons: first, and most importantly, they allow the doctor to ascertain whether or not the patient has evidence of tardive dyskinesia. If the patient presents these symptoms, every effort should be made to treat

him without the use of neuroleptic drugs. Second, the occasional discontinuation of the drug may afford a small amount of protection from the long-term hazards of these drugs. (D—"Klawans" TR. 20-30, 31, P—Kauff TR. 20-30, 31, lines 1-6, D—"Kobayashi" TR. 20-31, lines 21-25; 20-32, 33, lines 1-5.)

35.) Since drugs are administered to more and more people, and their effects are cumulative, the number of patients with abnormal motility is likely to increase steadily. A survey of a large population of chronic hospital patients showed that the percentage of persons with severe or moderately severe dyskinesia more than doubled over a period of three years. (P—"Crane—Two Decades" TR. 20-36, lines 14-23. P—Kauff TR. 20-36, lines 14-25.)

36.) In 1973 it was found that "...the mean prevalence for this disorder is about 15 percent (range, 3 to 40 percent), the risks of iatrogenically produced chronic neurologic disability are alarming." (P—Baldessarini and Lipinski" TR. 13-119, lines 1-7. P—Kauff Tr. 18-118, lines 18-23.)

37.) Tardive dyskinesia can be observed in at least 30 to 50 percent of patients who have been treated with drugs for several years. (P—Crane "Two Decades" Tr. 20-35, line 25; 20-36, lines 1-4. P—Kauff TR. 20-30, line 25; 20-30, lines 1-6. Plaintiffs Exhibit #31, page 173.)

38.) There is now convincing evidence that tardive dyskinesia is widespread among all patients receiving long-term neuroleptic drug therapy. Two recent surveys place the prevalence of tardive dyskinesia among chronically hospitalized schizophrenics at 50% and 56%. With respect to outpatients, one survey has reported a prevalence rate of 41.1%. Consequently, the prevalence of tardive dyskinesia may have been generally underestimated due to the failure of many clinicians to recognize its subtle signs. (Plaintiffs Exhibit #31, page 173.)

39.) Although this syndrome has been known since the late 1950's, the serious public health implications of its existence have only recently been appreciated since 1973. (D—*KANTAR* TR. 13-117, 118, 119. P—"Baldessarini and Lipinski" TR. 13-118, lines 14-19; 13-117, lines 17-25.)

40.) The fact that long-term exposure to drugs would eventually be accompanied by irreversible effects on the central nervous system, was predictable even in the early days of psychopharmacology. Although considerable information on these long-term effects has been available for many years, drugs are still administered in doses that are unsafe, as indicated by the large number of patients afflicted by encephalopathies. Also, the current policy of prescribing drugs in high doses for maintenance therapy are unnecessary. The excessive reliance on neuroleptics on the part of the medical community is as much a problem as the fact that these drugs are dangerous over the long-term. (P—"Crane—Two Decades" TR. 61-20, lines 19-24; 61-21, lines 23-25; 61-22, lines 1-17.)

(B.) *Akathisia*

41.)Akathisia is a syndrome induced by the various antipsychotic drugs. Akathisia has been described as the "itching foot syndrome." It's the inability to sit down or to stand still in one place. In addition, the patient feels an inner restlessness and is driven to move around. (P—DiMascio TR. 37-8, lines 22-25; 29-44, lines 16-21. D—*SZLYK* TR. 6-12, lines 8-11.) DR-41-48.) See Defendants' Proposed Findings of Fact, J-238, 240.

42.) Patients who experience akathisia feel discomfort from the inner restlessness and drive caused by the antipsychotics. They cannot sit still. They may pace. They may walk. If they're sitting down, their feet will be constantly shuffling. If they're standing in one place, they may be moving their feet up and down. (P—DiMascio TR. 37-9, lines 1-7. D-*SZLYK* TR. 6-12, lines 8-11.)

43.) Patients with akathisia exhibit continuous hyperactivity of the extremities and face an inability to sit or lie still, including mouthing movements, lip-smacking, licking of the lips, increased blinking, grimacing and continuous aimless movements of the tongue. (D—"Schmidt and Jacob" TR. 19-91, lines 7-21. P—Kauff TR. 19-91, lines 7-25.)

44.) Patients of middle age are most susceptible to akathisia with females predominating over males in frequency. (P—"Greenblatt, Shader, DiMascio"; P—DiMascio TR. 35-132, lines 19-25; 35-133, lines 1-7.)

45.) Even though akathisia is reversible, it is one of the most resistant to treatment. This side effect affects a patient for the longest natural time course of all the neurological side effects, described as extrapyramidal side effects. (P—DiMascio TR. 35-133, lines 13-18; 29-45, lines 1-9.)

46.) A patient can subjectively experience akathisia without a physician detecting the existence of the syndrome. The only way in which a physician or psychiatrist finds out if the patient is suffering from the syndrome is by asking the patient about it and how he feels when and if he notes movement; or if the patient has no movement, only if the patient will volunteer the information, or if the physician happens to ask the patient about it. (P—DiMascio TR. 37-9, lines 12-20.)

47.) Akathisia is very often misdiagnosed by physicians. It is very often misdiagnosed as agitation rather than as an iatrogenic disorder. Patients who experience this side effect often worsen. Physicians often misdiagnose the drug induced worsening and mistakenly raise the dosage of the medication being prescribed, thereby inducing further worsening. (P—DiMascio TR. 35-132, lines 9-18).

48.) Approximately 12.5 percent to 21.2 percent of patients on antipsychotics experience akathisia. (P—DiMascio TR. 37-10, 11, lines 1-9. P—"Ayd" TR. 37-10, lines 23-25; 37-11, lines 1-5.)

(c.) *Pseudo Parkinsonism*

49.) Another adverse reaction caused by the neuroleptic drugs themselves is what is called "pseudo-parkinsonism syndrome." This syndrome looks like somebody who has parkinson's disease: mask-like face, rigidity of the hand, so that as you move the wrist, it's like a cogwheel effect.D—*SZLYK* TR. 6-11, lines 21-25.)

DR-49-50.) See Defendants' Proposed Findings of Fact, J-241, 242.

50.) Approximately 53 percent of patients on antipsychotics experience parkinson's like syndrome. (P—DiMascio TR. 37-10, lines 11-14.)

DR-50.) The figure of 53 percent of patients on antipsychotic drugs experiencing parkinson-like syndrome is based on only one study. In another study cited in the same article used by the plaintiff the figure was only 15.4 percent. Tr. 37 at 11 (DiMascio).

(D.) *Akinesia*

51.) Another neurological side effect of antipsychotic medication is akinesia, which in severe cases is characterized by physical immobility as well as lack of spontaneity and emotional indifference. (D—*KANTAR* TR. 13-91, lines 12-21. D—*SZLYK* TR. 6-12, lines 1-7.)

Dr-51-53.) See Defendants' Proposed Findings of Fact, J-238-239.

52.) Akinesia is an extrapyramidal side effect where the patient feels the lack of mobility to move. Often associated with this is a decrease in their facial movements and a reduced ability to express emotions facially. There is also a depressant like reaction that is associated with akinesia. (P—DiMascio TR. 29-43, lines 1-9.)

53.) Akinesia is closely associated with such other neurological symptoms as parkinsonism. It is definitely an undesirable reaction and a clear sign of overdosage. These

sedative effects are unpredictable and are often mistaken for apathy, inactivity, and the loss of psychomotor spontaneity. (P—"Crane—Two Decades" TR. 20-23, lines 4-16. P—Kauff TR. 20-23, lines 4-22).

DR-53.) According to Dr. Brill, the appearance of akinesia does not indicate that medication dosages are so high as to be unacceptable medical practice. Moreover, the extra pyramidal effects of akathasia are short-lived and respond to antiparkinsonian medication. Tr. 57 at 83, 84 (Brill).

(E.) *Dystonia*

54.) There are also neurological reactions to antipsychotic drugs called dystonia. Its manifestation include spasmodic muscles' reaction, such as twisting of the neck, spasms of the neck and the facial muscles, arching of the back, and spastic movements of the various muscles of the body. In addition, sometimes the eyes roll back into the head so you see only the whites of the eye. Furthermore, a dystonic reaction may include a protrusion of the tongue. (P—DiMascio TR. 29-44, lines 1-8.)

DR-54-57a.) See Defendants' Proposed Findings of Fact, J-243. See Defendants' Proposed Findings of Fact, F-247, K-241-243.

55.)When a patient has dystonia, muscles are contracted involuntarily and the patient is in pain at that point. A patient then has to be given medication to relieve the dystonic reaction. (D—*SZLYK* TR. 6-11, lines 10-20. P—DiMascio TR. 29-44, lines 1-9.)

56.) Dystonia can be painful or very uncomfortable to patients experiencing it. (D—*SZLYK* TR. 6-11, lines 10-20. D—Brill Tr. 57-137, lines 1-3.)

57.) Neurileptic induced side effects as dystonia, akathisia and pseudo parkinsonism can be as disabling as tardive dyskinesia and can occur with equal and greater frequency, but they are reversible when drug therapy is discontinued or

when an antiparkinsonian agent is administered concomitantly. (Plaintiffs Exhibit #31, page 173.)

57a.) Patients experience distress as a result of being subjected to adverse side effects, including pseudo parkinsonian and dystonic reactions. (D—*SZLYK* TR. 6-13, lines 16-25; 6-14, lines 1-5.)

(F.) *Antiparkinson Drugs for Treatment of the Neurological Side Effects*

58.) 'Antiparkinson' drugs are of some value in alleviating dystonias and the rigidity of the parkinsonian reaction. But although drug-induced extrapyramidal side effects respond somewhat more favorably to antiparkinson medication than do the symptoms of true parkinsonism, most patients will still experience only partial relief of phenothiazine-induced side effects, with some patients finding no relief at all. The antispasmodics often fail to produce remission of the symptoms of diskinesia, akathisia, and the parkinsonian tremor. (P-DiMascio TR. 37-6, lines 20-25; 37-7, lines 4-21. P-"Greenblatt, Shader and DiMascio" TR. 37-6, lines 20-25; 37-7, lines 4-21.)

59.) Antiparkinson drugs also cause toxic reactions and 'mental symptoms' of its own. Some toxic effects include blurred vision, constipation, and gastrointestinal disturbances. (P-DiMascio TR. 37-7, lines 21-25; 37-8, lines 1-4. D-Brill TR. 61-6, lines 18-24.)

60.) There is also some recent evidence developed that antiparkinson drugs may diminish the psychotropic value of the antipsychotic therapy. (P-DiMascio TR. 37-8, lines 7-11.)

61.) Antiparkinsons increase the intensity and duration of tardive dyskinesia in any patient who is prone to develop this type of abnormal movements. They also worsen chorea in choreatic patients on neuroleptic therapy. The attempt to relieve one of the neurological complications of neuroleptic therapy thereby may promote the appearance of another, more severe, longer lasting, and less reversible neurological

complication. Besides prolonging and potentiating tardive dyskinesias, there is also some evidence to suggest that antiparkinson drugs may alter the threshold for the appearance of tardive dyskinesias. Therefore antiparkinson agents may not only increase the severity of tardive dyskinesias in patients prone to this type of movement disorder but may also increase the incidence of tardive dyskinesias by altering the threshold for the appearance of these movements. This suggests that the incidence of tardive dyskinesias should be greater in patients receiving both neuroleptics and anticholinergics than in patients receiving neuroleptics alone. This appears to be true. (P-"Klawans" TR. 18-59, lines 15-29; TR. 18-60, lines 1-18; 18-61, lines 5-9. P-Kauff TR. 18-59, lines 15-29; 18-60, lines 1-18; 18-61, lines 5-9; 18-61, lines 18-25; 18-62, lines 1-6.)

DR-61.) The data in Klawans' article "The Pharmacology of Tardive Dyskinesia" does not support the conclusion that antiparkinson drugs predispose patients to develop tardive dyskinesia. Tr. 42 at 18-21 (Tarsy).

(G.) *Dysphoria*

62.) In addition, antipsychotics cause patients to experience a dysphoric reaction. This dysphoric reaction is described by patients as making them feel 'goofy,' 'lazy,' 'mummified,' 'dull,' or 'fuzzy'; one described the effects of chlorpromazine (thorazine) as a 'cheap drunk,' another as a 'hangover without a headache.' Forty percent of those who took antipsychotic drugs had a dysphoric reaction. Eighty-eight percent of the dysphoric responders eventually refused to continue taking chlorpromazine because of a persisiting dysphoria, against only 23 percent of the euphoric responders. Although dysphoric responders on the average were treated with much the same dose as the euphoric responders, most of them complained throughout their treatment with chlorpromazine of feeling 'drugged,' of having 'no drive or ambition,' of being 'drowsy,' or 'tired,' and 'slowed-up.' " (P-"Van Putten" TR. 34-23, 24, lines 1-12. P-Whitaker TR. 36-68, lines 10-15.)

DR-62.) (1) Sedative effects of antipsychotic medication, while predictable during the early phases of administration, wear off and usually last no more than a couple of weeks. Tr. 57 at 65 (Brill).

(2) While Dr. Whitaker testified that the Van Putten article, "Drug Refusal in Schizophrenia and the Wish to Be Crazy" was authoritative, he meant no more than that the article was useful. He did not know whether anyone had ever cited the article. Tr. 36 at 30-32 (Whitaker).

(3) The Van Putten article, "Subjective Response as A Predictor of Outcome in Pharmacotherapy" was not a triple blind contolled study. Tr. 36 at 30 (Whitaker). While Dr. Whitaker testified that the article was authoritative, he meant no more than that it was useful. He did not know whether anyone had ever cited the article. Tr. 36 at 31-32 (Whitaker).

(4) In the Van Putten article, 60% of the patients had an initial euphoric response. Tr. 36 at 68 (Whitaker).

(5) Van Putten concludes that the general usefulness of antipsychotic drugs has been reasonably established and research has now advanced to trying to predict the results of pharmacotherapy in the individual patient. Tr. 36 at 68-70 (Whitaker).

(6) Van Putten's conclusion regarding subjective responses to medication as a predictor of outcome are only preliminary and in need of replication. Tr. 36 at 70 (Whitaker).

(H.) *Behavioral Toxic Reactions — Paradoxical and Pendular Reactions*

63.) Antipsychotic drugs may cause adverse reactions similar to some of the symptoms of psychosis. These reactions are called paradoxical reactions. These 'paradoxically' induced acute psychotic reactions are marked by confusion, incoherent rambling, disorientation, paranoid ideation, increased agitation and excitement, violent maniacal behavior, visual and auditory hallucinations or by depersonalization. (D-*KANTAR* TR. 13-69, lines 13-23. P-"DiMascio" TR. 13-72, lines 15-25; 13-73, lines 1-3 (introduced through D-*KANTAR*). P-DiMascio TR. 29-45.)

DR-63-69.) (1) While Dr. Whitaker testified that in his opinion the DiMascio, Giller and Shader article, "Behavioral Toxicity of Psychotic Drugs" was authoritative, Dr. Whitaker had never read the article until Mr. Cole showed it to him and did not know if anyone had ever cited the article. Tr. 36 at 32-33 (Whitaker).

(2) DiMascio, Giller and Shader note that the adverse effects to medication they describe are not an essential accompaniment to drug administration. They also note that these effects are specific to dosage levels, personality characteristics and length of drug usage. The authors also note that similar adverse effects have been claimed by some from psychotherapy. Tr. 36 at 76-77 (DiMascio, Giller and Shader, "Behavioral Toxicity of Psychotic Drugs", p.772). See also Defendants' Proposed Findings of Fact, J-245, 246.

64.) Another behavioral toxic effect of the antipsychotic drugs are pendular reactions. At times when a doctor treats a particular extreme condition with an antipsychotic, it causes the patient to move over into the opposite extreme condition. For example, in a patient who is depressed, a doctor treats a patient with an antidepressant and the antidepressant may relieve the depression, but the patient will swing over to the other direction and become somewhat manic. (P-DiMascio TR 37-11, lines 11-18.)

65.) It has been suggested that paradoxical and pendular toxic reactions are merely the uncovering of latent schizophrenic symptoms, but others argue against this view since they cite cases showing that they appear in previously nonpsychotic individuals. (P-"DiMascio" TR. 13-73, lines 3-7 Introduced through D-*KANTAR*.)

66.) The impression is gained in reading the literature that these drug-induced 'behavioral side-effects', (pendular and paradoxical) are relatively rare and unexpected sequelae of drug administrations. The probability is, however, that these drug actions are really neither as rare nor as expected as the

literature would have one believe. (P-"DiMascio, Shader, Harmatz" TR. 37-11, line 24-25; 37-12; 37-13, lines 1-6.)

67.) The reason why the medical profession has underestimated the extent of drug induced behavioral toxicity includes the fact that the definition of what constitutes or what is to be included under the term of behavior toxicity has never really clearly been set down. Second is that the symptom complex of what may be considered as behavior toxicity is so highly intertwined with the mental status of the patient that it has been difficult to recognize and isolate the former. (P-DiMascio TR. 13-72, lines 6-21 (introduced through D-*KANTAR*); 13-73, lines 11-15.)

68.) Regardless of the frequency of such behavioral toxic effects, when it occurs they have disasterous consequences — both therapeutically and potentially to the health of the patient. (P—"DiMascio, Shader and Harmatz" TR. 37-11, line 24-25; 37-12, lines 1- ; 37-14, lines 24, 25; 37-15, line 1-9.)

69.) Behavioral toxic effects can be disruptive of the treatment of patients and will delay the patient's return back out into society. These toxic effects will cause interference with the total treatment program. It may cause the patient to become more psychotic than he is. It will cause a number of things which are not adaptive and not in the best interests of the patient. (P-DiMascio TR. 37-13, lines 20-25; 37-14, line 1-2.)

(I.) *Adverse effects to the Cardiovacular system*

70.) Next to the nervous system, the cardiovascular organs are the most vulnerable to antipsychotics. While hypotension is temporary and usually subsides after a few days of therapy, electrocardiographic changes due to electrolyte imbalance often persist for as long as the patient is on medication. There is sufficient evidence to indicate that these changes are the forerunners of permanent and often lethal cardiac complications. (P—"Crane-Two Decades" TR. 37-18, lines 13-25. P-DiMascio TR. 37-16, lines 4-25; 27-17, lines 1-23.)

DR-70.) (1) While there are electrocardiographic changes which accompany the use of certain of the antipsycotic drugs in some patients, the issue is still open whether the drugs cause cardiac difficulties. Tr. 57 at 74 (Brill); Tr.37 at 17-18 (DiMascio). Moreover, the cardiac effects are reversible when the medication is withdrawn or changed. Tr. 57 at 74 (Brill). (2) While cited in support of plaintiffs' finding, Dr. DiMascio did not agree with this finding. He was simply on the witness stand when this article was read.

(J.) *Adverse effects on perceptual and mental functions* 71.) When antipsycotic drugs (chlorpromazine) alter perceptual processes they act to slow them down slightly and to dull their sensitivity (i.e., threshold). Drugs-induced alterations in perceptual phenomena have included impairment of such diverse processes as size estimation, auditory discrimination, detection of apparent motion, concentration of focus of attention, and rate of stimuli influx per unit time. With regard to those mental functions that are essential to the processing, storage and incorporation of information to be used in guiding behavior, considerable evidence exists in humans indicative of drug-induced decreased efficiency. Memory (immediate recall) was impaired in both normals and in schizophrenic, psychoneurotic and depressed patients undergoing drug therapy with chlorpromazine. Reasoning ability (organizational and problem solving ability), and capacity to abstract (judgment and learning of conceptual relationships) declined after chlorpromazine. The mental speed with which a simple task (arithmetic ability) was carried out was slowed by chlorpromazine. Learning (incorporation of new information or new relationships) was deleteriously affected in normals and in patients undergoing drug therapy: chlorpromazine has been shown to retard the learning process. (P-"DiMascio-Behavioral Toxicity" TR. 33-92, lines 11-25; 33-93, lines 1-25; 33-94, lines 1-19. P-Whitaker TR. 33-91, lines 23-25; 33-92, lines 1-2, 11-25; 33-93, lines 1-2; 33-94, lines 1-21; 34-19, lines

1-6. P-Messinger TR. 31-95, lines 14-25; 31-96, lines 1-13.)

DR-71.) (1) While on normal people and experimental animals antipsychotic medications have a dampening effect, where one is dealing with a psychosis, there is a dampening effect on the psychosis but there is a net gain in the patient's behavior, in the patient's feelings and adjustments. Tr. 57 at 63 (Brill).

72.) Additional problems with long-term maintenance chemotherapy are suggested by literature dealing with animals, normal subjects and psychiatric patients. Such studies indicate that learning under a variety of psychotropic drugs is not only less efficient than learning in the nondrug state but, more importantly, that transfer of learning acquired during drug states to nondrug states is minimal. (P-"Paul, Tobias, Holly" TR. 33-95, lines 13-25; 13-96, lines 1-5. P—Whitaker TR. 33-95, lines 13-25; 13-96, lines 1-14. D-*KANTAR* TR. 13-76, lines 18-25. P-Messinger TR. 31-95, lines 14-25; 31-96. P-Kauff TR. 18-24, lines 24-25, 18-25 lines 1-15; 18-77, lines 24-25; 18-78, lines 1-19.)

DR-72.) (1) Paul, Tobias and Holly's statement that studies indicate that learning under a variety of psychotropic drugs is not only less efficient than learning in the non-drug state, but more importantly the transfer of learning acquired during drug states to non-drug states is minimal, is not supported by the footnotes to which they cite to support their statement. Tr. 64 at 78-82 (Gill).

(2) Animal experimentation with antipsychotic drugs is of limited relevance as there is no parallel for animals to the psychotic state in human beings. Tr. 57 at 55 (Brill).

(3) In fact, learning accomplished while receiving antipsychotic drugs remains with the patient when off antipsychotic medications. Tr. 57 at 67-68 (Brill); Tr. 35 at 84-85 (DiMascio). See also Defendants' Proposed Findings of Fact, J-197, 198.

(4) Dr. Kantar stated only that if a person is medicated, it might interfere with her ability to learn, but this has to be weighed against what other processes are going on in the patient which might interfere with her ability to learn. Tr. 13 at 76 (Kantar).

73.) For some patients antipsychotic medication will impair their attention to detail, reduce attention span, and reduce the ability to retain facts. (P-DiMascioTR. 29-53, lines 22-25; 29-54, lines 1-8. P-Kauff TR. 18-77, lines 24-25; 18-78, lines 1-19. See also proposed finding #71.)

DR-73.) Dr. Dimascio, in fact, testified that the effects of psychotropic drugs vary with the particular patient; such drugs my either increase or decrease attention span or retention. Tr. 29 at 53, 54 (DiMascio).

74.) For some patients antipsychotics will slow the speed of thought processes. (D-*POMERANTZ* First Set of Admissions 39(13). D-*OSBORNE* First Set of Admissions 39(13). P-DiMascio TR. 35-117, lines 23-25; 35-117, lines 1-2. P-Messinger TR. 31-95, lines 14-25; 31-96, lines 1-3. P-Kauff TR. 18-77.)

DR-74.) (1) Dr. DiMascio, when asked whether it is more probable than not that antipsychotic drugs lead to a slowing of thought processes, testified that "it would depend on the particular patient and the particular situation" (Tr. 35 at 117, 117A). Drs. Pomerantz and Osborne did not state that for some patients antipsychotics will slow the speed of thought processes (Dr. Pomerantz, First Set of Admissions, 39-13; Dr. Osborne, First Set of Admissions, 39-13).

(2) See defendants' Proposed Findings of Fact, J-200, J-210. See also Defendants' Response to Plaintiffs' Proposed Findings (Medication - General) 69, 71.

75.) The use of antipsychotic agents, especially in higher doses, leads to slowing of thought processes and clouded mind and clouded consciousness. (D—*POMERATZ* First Set of Admissions #39(13). D-*OSBORNE* First Set of Admissions

#39(13). P-Messinger TR. 31-95, lines 14-25; 31-96, lines 1-3. P-DiMascio TR. 35-117, line 23-25; 35-117a, lines 1-2. P-Kauff TR. 18-77, lines 24-25; 18-78, lines 1-19; 18-24, lines 23-25; 18-25, lines 1-15. See also proposed finding #71-73, 76, 77.)

DR-75.) See Defendants' Proposed Finding of Fact, J-187 and Defendants' Response to Plaintiffs' Proposed Finding (Medication - General), #74.

76.) Some retarded and other patients find themselves working through a sedative haze which will interfere with learning. The side effects include change in acuity, visual acuity, the development of unwanted motor side effects such as parkinsonian rigidity or tremors, uncontrollable agitation, hyperactive motor signs called akathisia or akinesia, a state in which there is total loss of motor spontaneity. All of these things can interfere with learning and can occur in someone who may not be able to make these changes known to his physician. (P-Kauff TR. 18-24, lines 23-25; 18-25, lines 1-15.)

DR-76.) See Defendants' Response to Plaintiffs' Proposed Findings (Medication - General) 69, 71.

77.) It is not uncommon to observe psychiatric patients who are lethargic, disinterested, asocial or behaving oddly. Frequently these symptons are attributed to illness and not to medication. Yet, when dosages are reduced or drugs discontinued, a favorable transformation occurs in these patients. They become alert, talkative, sociable, showing a broadening of interests, have more drive, and much of their odd behavior vanishes. Clearly, these patients were 'drugged' and much of their strange behavior was medication-induced. (P-"Ayd Symposium" TR. 61-13, lines 1-6; 61-15, lines 3-17. D-Brill TR. 61-15, lines 3-23.)

DR-77.) (1) The emphasis of this statement by Dr. Ayd was on combinations of drugs not necessarily even combinations of antipsychotics. Moreover, Dr. Brill points out that Dr. Ayd emphasized problems of underdosage as well, and that what

Dr. Ayd was pleading for was "good clinical judgment based on reasonable pharmacological experience and knowledge." Tr. 61 at 15 (Brill).

(2) The fact that patients can be overmedicated is not relevant to the effects of medication when given at proper dosages. Dr. Ayd, in fact, uses antipsychotic medication in his practice. Tr. 61 at 35-36 (Brill).

78.) Antipsychotic medication interferes with patients' ability to learn, impairing reasoning, and memory. (D-*KANTAR* TR. 13-76, lines 18-25. P-Whitaker TR. 33-95, lines 1-25; 13-96, lines 1-14. P-"Paul, Tobias, Holly" TR 33-95, lines 13-25; 13-96, lines 1-5. P-DiMascio-Behavioral Toxicity" TR. 33-92, lines 11-25; 33-93, 94, lines 1-19. P-Messinger TR. 31-95, lines 14-25; 31-96. P-Kauff TR. 18-24, lines 24-25; 18-25, lines 1-15; 18-77, lines 24-25; 18-78, lines 1-19. P-"Ayd Symposium" TR. 61-13, lines 1-6; 61-15, lines 3-17. D-Brill TR. 61-15, lines 3-23.)

DR-78.) (1) Dr. Kantar did not state that antipsychotic medication neccessarily interferes with patients' ability to learn, impairing reasoning and memory. Dr Kantar stated only that medication might interfere with a patient's ability to learn, but this had to be weighed against other processes which were going on in the patient which might interfere with her ability to learn." Tr. 13 at 76 (Kantar). Dr. Brill did not state that antipsychotic medication interferes with patient's ability to learn, or impairs reason or memory. He agreed with the conclusions of the Ayd Symposium only as he qualified them. See Defendants' Response to Plaintiffs' Proposed Finding (Medication - General) #77.

(2) See Defendants' Proposed Findings of Fact, J-181, 185, 197, 198. See Also Defendants' Response to Plaintiffs' Proposed Findings (Medication - General) #71.

78a.) For some patients, there is a decrease in functions related to adaptive functioning, including perception, cognition, speed of response, which actually interfere with adaptive functioning. The drugs make the patients more tractable, less distrubing, but they have an interferring effect on the patient's ability to function adaptively outside as well as inside the hospital. (P-Whitaker TR. 33-95, lines 1-12. P-"DiMascio -Behavioral Toxicity" TR. 33-92, lines 11-25; 33-93, 94, lines 1-19. P-Messsinger TR. 34-95 lines 14-25; 31-96, lines 1-3.)

DR-78A.) (1) This finding is merely Dr. Whitaker's interpretation of a DiMascio article. Tr. 33 at 85 (Whitaker). However, Dr. DiMascio testified that antipsychotic drugs are useful in speeding up the remission of symptoms and the return of the patient into society. Tr. 29 at 56 (DiMascio).

(2) Moreover, Dr. DiMascio testified that antipsychotic medications do not increase conformity and he believes that they may aid the patients in returning back to the previous state, but that they do not cause people to be more like one another or more like some given standard. Tr. 29 at 52 (DiMascio). See also Defendants' Proposed Findings, J-204-206, 208, 211.

(K) *Reduction of Drive, Initiative and Planning Ability*

79.) For some patients, medication contributes to institutionalism by reducing drive, initiative and planning ability. (P-"Prien and Caffey" TR. 57-137, lines 16-25; 57-138, lines 1-10. P-"Prien" TR. 33-97, lines 10-15. P-Whitaker TR. 33-97, lines 10-25; 33-98, lines 1-19; 33-95, lines 14-18. P-Messinger TR, 31-96. P-DiMascio TR. 35-118, lines 7-13. P-Kauff TR. 18-77, lines 24-25; 18-78, lines 1-19; 20-23, lines 4-22. P-"Ayd Symposium" TR. 61-13, lines 1-6; 61-15, lines 3-17. D-Brill TR. 61-15, lines 3-23. P-"Crane - Two Decades" TR. 20-23, lines 4-16.)

DR-79.) (1) Neither Dr. DiMascio nor the Ayd Symposium nor Dr. Brill stated that for some patients medication contributes to institutionalism by reducing drive, initiative, and

planning ability. (Tr. 118, lines 7-13, P-"Ayd Symposium", Tr. 61 at 13, lines 1-6; 61-15, lines 3-17; Dr. Brill Tr. 61 at 15, lines 3-23).

(2) It is the main purpose of antipsychotic medications to reduce the psychotic drive and psychotic initiative which makes it impossible for an individual to get along outside of an institution and makes life in the institution extremely difficult for him and for others. Tr. 61 at 42 (Brill). See also Defendants' Proposed Findings of Fact, J-201, 203.

(3) While Dr. Whitaker testified that the Prien paper found in the "Symposium: Active Treatment of Chronic Schizophrenia" was authoratative, Dr. Whitaker had never read the article until Mr. Cole showed it to him, did not know who Dr. Prien was, and did not know if anyone had ever cited the article. Tr. 36 at 34-36 (Whitaker).

80.) Antipsychotic drugs will cause patients to be more passive. (P-DiMascio TR. 35-118, lines 7-13. P-Messinger TR. 31-96, lines 6-18. P-Kauff TR. 18-77, lines 24-25; 18-78, lines 1-19. P-"Ayd Symposium" TR. 61-13, lines 1-6; 61-15, lines 3-17. D-Brill TR. 61-15, lines 3-23.)

DR-80.) Dr. DiMascio did not say that antipsychotic drugs will cause patients to be more passive. He in fact said that there is no good data one way or the other whether antipsychotic drugs lead more probably than not to more passivity on the part of the patient. Tr. 35 at 118 (DiMascio). The Ayd Symposium only stated that it was "not uncommon" to observe psychiatric patients on antipsychotic drugs who are "lethargic," not that antipsychotic drugs necessarily cause patients to be more passive. Tr. 61 at 15 (Brill). Dr. Brill did not state that antipsychotic drugs will cause patients to be more passive. He stated that medication may cause "a quietness and a reduction of aggressive behavior which may look like passivity, but the net result is again an improvement in constructive activity." Tr. 57 at 62 (Brill).

DR-80 & 81.) (1) See Defendants' Response to Plaintiffs' Proposed Finding 78A. See also Defendants' Proposed Finding of Facts J-192A, 211.

(2) Halleck states only that tranquilization, and not that drug therapy, increases conformity and decreases assertiveness. While Halleck makes this bald assertion, he offers no support for the statement. Tr. 36 at 78-81 (Whitaker).

81.) Tranquilization through antipsychotics is likely to increase conformity and decrease assertiveness. (P-"Halleck". P-Whitaker TR. 36-78, lines 23-25; 34-36, 37, 38. D-*KANTAR* TR. 14-37, lines 15-25; 14-38, 39.)

DR-81.) Dr. Kantar did not state that tranquilization through antipsychotics is likely to increase conformity and decrease assertiveness. He stated only that as patients' anxieties are reduced, they are more likely to become cooperative and to conform to certain programs. Tr. 14 at 37 (Kantar).

(M.) *Reduction in Spontaneity*

82.) As a result of antipsychotics, some patients function in a less alive, spontaneous manner, and, though that patient may not be as disturbing, that patient's ability to relate spontaneously to others is hampered. (P-Whitaker TR. 33-100, lines 8-18; 36-68, lines 10-15. P-Messinger TR. 31-96, lines 14-22. P-Kauff TR. 18-77, lines 24-25; 18-78, lines 1-19; 20-23, lines 4-22. P-"Crane - Two Decades" TR. 20-23, lines 4-16. P-"Van Putten" TR. 34-23, 24, lines 1-12. See also Proposed Finding ¶79, ¶80.)

DR-82.) (1) The Crane article said only that the loss of psychomotor spontaneity is a sign of overdose, and not that antipsychotics neccessarily cause losses in spontaneity. "Crane-Two Decades", Tr. 20 at 23, lines 4-16.

(2) See Defendants' Proposed Finding of Fact, J-206. See also Defendants' Response to Plaintiffs' Proposed Findings (Medication - General), ¶62.

(N.) *Induce or reinforce social isolation, and depression*

83.) Recent evidence has more carefully documented the relationship between drug treatment and the inducement or reinforcement of defect or negative symptoms, including anhedonia, social isolation, post-psychotic depression, and amotivational syndromes. (P-"Carpenter, McGlashan and Strauss" TR. 33-99, lines 7-14; 33-100, lines 19-25; 33-101, line 1; 36-88, lines 1-10.)

DR-83-85,) (1) In support of their statement that there is a relationship between drug treatment and anhedonia, social isolation, postpsychotic depression and a motivational syndromes, the authors cite only three references. These references do not support the author's conclusions. Tr. 36 at 88-92 (Whitaker).

(2) Moreover, while some patients recovering from psychosis and treated with antipsychotic drugs experience postpsychotic depression, some patients recovering from psychosis suffered from postpsychotic depression before the introduction of antipsychotic drugs. Tr. 57 at 58-59 (Brill). See Defendants' Proposed Finding J-195, 205 (re. social isolation), J-209 (re. anhedonia) and J-207 (re. motivation).

84.) Antipsychotics cause and induce or reinforce social isolation in patients, as well as induce or reinforce postpsychotic depression and amotivational syndromes. (P-"Carpenter, McGlashan and Strauss" TR. 33-99, lines 7-14; 33-100, lines 19-25; 33-101, line 1; 36-88, lines 1-10. P-Whitaker TR. 33-100, lines 2-4. P-DiMascio TR. 29-54, lines 9-19. P-Messinger Tr. 31-96, lines 14-22.)

DR-84.) Dr. DiMascio did not say that antipsychotics cause and induce or reinforce social isolation. He said that the effect of antipsychotic drugs upon patients' social interactions depended upon the particular patient. Tr. 29 at 54 (DiMascio).

(O.) *Reduce Ability to Experience Pleasure*

85.) In addition, antipsychotics may reduce the capacity to experience emotions, social stimulation and therefore reduce the capacity or ability to experience pleasure. (P-Whitaker TR. 33-100, lines 19-25; 33-100, lines 1-14. P-"Carpenter, McGlashan and Strauss" Tr. 33-99, lines 7-14; 33-100, lines 19-25; 33-101, line 1.)

(P.) *Autonomic Side Effects*

86.) There are autonomic side effects particular to antipsychotic agents. These autonomic responses include temporary lowering of blood pressure, which is called hypostatic tension. Hypostatic effects usually pass after perhaps seven or ten days after a doctor starts medication. Sometimes, patients on Thorazine, in fact, lie in bed beause of the hypostatic tension, or when they first get out of bed, they sit at the side of the bed until their body responds and then they stand up. Other autonomic effects include blurred vision, dryness of the mouth, and transient effects on the bladder and on the GI tract, such that some patients might become constipated. In addition, some patients have urinary retention for a period of time. (D-*SZLYK* Tr. 6-7, lines 17-25; 6-8, lines 1-14. D-Brill TR. 57-7, lines 1-6.)

(Q.) *Adverse effects on the Endocrine System*

87.) There are also adverse effects on the endocrine system. Phenothiazines effects the hyperpituitary access which affect certain hormone release factors so that sometimes there is amenorrhea, which is a disruption of the menstrual cycle. There can be what is called galactorrhea, which is a secretion from the nipple of the breast. There can be in the case of men inhibition of ejaculation. There are what are called "skin changes" caused by antipsychotics. There can be sort of grayish discoloration of the skin. There can also be allergic rashes. There can also be effects on the cornea of the eye in the lens in some cases which would be opthalmological. There can be liver effects, such that the antipsychotic acts seem to have

an effect on the bile system which can lead to cholestatic jaundice. There is also an effect on the bone marrow. You could have agranulocytosis, which is usually possible to take place within three to eight weeks of starting phenothiazine. The white cells selectively are depleted, namely, the agranulcytes of the white blood cells are depleted as opposed to the lymphocytes. The consequence of that is that somebody would be highly susceptible to a bacterial type of infection. (D-*SZLYK* TR. 6-10, lines 5-25; 6-11, lines 1-9.)

(R.) *Other Risks of Antipsychotic Drugs*

88.) For many hospitalized schizophrenics pill taking on a.o.d., b.i.d., or t.i.d. basis comes to represent a way of life and a testimonial to the "sick" status of the patients. The queing of patients at the nurses's station to receive their daily pills also has many features of a social event for it represents at least one formal time during the day that they can have brief interaction with staff and receive some token assurance that they are being treated and taken care of. Moreover, as part of the medicated way of life, patients come to depend on drugs as a means of quelling all their feelings and thereby achieving a state of emotional numbness by this drug-taking ritual and they never really have the opportunity to live with and live through the many anxieties and fears which originally brought them to the hospital and which contribute to their apprehension about leaving. In a sense, they have become conditioned to lead a pseudo-Parkinsonian, zombie-like existence. (P-"Caffey ymposium" TR. 33-103, lines 22-25; 33-103, line one; 33-105, lines 1-19. P. Whitaker TR. 33-102, lines 22-25; 33-103, line 1; 33-105, lines 1-19; 33-107, lines 4-5.)

89.) From the prospective of hospital staff, their excessive reliance on drugs absolves them of the responsibility of becoming more intimately and humanly involved with patients and actively searching for other therapeutic modalities. Whenever patients become upset, staff often respond by changing the dose of medication, rather than uncovering and

resolving the sources of difficulty. (P-"Caffey Symposium" TR. 33-102, lines 22-25; 33-103, line 1; 33-105, lines 19-25; 33-106, lines 1-2. P-Whitaker TR. 33-102, lines 22-25; 33-103, line 1; 33-105, lines 19-25; 33-106, lines 1-2; 33-107, lines 4-5.)

90.) The automatic dispensing of drugs serves another function for staff. As long as drugs are given, despite a lack of therapeutic response, staff can solve their professional consciences that they are doing something for patients. This practice alleviates complaints from families and hospital administrators regarding treatment, since drugs represent a legitimate, sanctioned, medical treatment procedure. Unfortunately, this practice can foster a sense of therapeutic indulgence and complacency among hospital staff regarding their treatment obligations to patients. (P-"Caffey Symposium" TR. 33-102, lines 22-25; 33-103, line 1; 33-106, lines 8-21. P. Whitaker TR. 33-102, lines 22-25; 33-103, line 1; 33-106, lines 8-21; 33-107, lines 4-5.)

91.) Because of the perfunctory dispensing of drugs, it is not uncommon to find patients taking medications for years without any periodic assessment of whether they continue to need these drugs or perhaps even function better without them. Once patients are started on these drugs, even if they show no progress, they are likely to remain on them in perpetuity. (P-"Caffey Symposium" TR. 33-102, lines 22-25; 33-103, line 1; 33-106, lines 2-8. P-Whitaker TR. 33-102, lines 22-25; 33-103, line one; 33-106, lines 2-8; 33-107, lines 4-5.)

(III) *ADVERSE EFFECTS FROM THE ANTIPSYCHOTIC DRUGS ACTUALLY EXPERIENCED BY THE NAMED PLAINTIFFS AND THE PLAINTIFFS' CLASS*

92.) Many patients taking phenothiazines as part of a planned therapeutic program have had adverse effects on their mood and personality. (D-*POMERANTZ* First Set of Admissions #39(14). D—*OSBORNE* First Set of Admissions #39(14). See Plaintiff's Exhibit No. 34.)

DR-92.) Dr. Pomerantz admitted that his patients taking neuroleptic drugs had effects on their mood but did not admit that they had effects on their personality. Neither Dr. Pomerantz nor Dr. Osborne admitted that any effects on mood or personality were "adverse", rather than beneficial, nor did they admit that "many" of their patients had such effects. (Dr. Pomerantz First Set of Admissions #39-(14). Dr. Osborne First Set of Admissions #39-(14).)

93.) Many members of the plaintiff class have had their minds clouded from taking phenothiazines. The antipsychotics also affected many patients' ability to concentrate. (D-*POMERANTZ* First Set of Admissions #39(13). D-*OSBORNE* First Set of Admissions #39(13). See Plaintiff's Exhibit No. 34.)

DR-93.) Drs. Osborne and Pomerantz did not say whether the effects of antipsychotic drugs upon their patients' ability to concentrate and upon the clouding of their minds were adverse or beneficial, or whether they were temporary or permanent. (Dr. Pomerantz Fisrt Set of Admissions, #39(14). Dr. Osborne First Set of Admissions #39(14).) Dr. Schildkrout specifically noted that the medication usually increased the patient's ability to concentrate and decreased any cloudiness of mind. (Dr. Schildkrout First Set of Admissions #39(14).)

94.) Many patients of the plaintiff class taking phenothiazines as part of a planned therapeutic program have had the following side effects:

1) Tardive dyskinesia (D-*MAZMANIAN, SZLYK, GOLDBARG, CACCIOLA, SEIL* First Set of Admissions #39(1). D-B. Schildkrout TR. 41-73.)

2) Parkinsonism (D-*KAHN, KANTAR, MALAMUD, SCHILDKROUT, SIEGEL, SZLYK, TURNQUEST, GILL, GOLDBARG, CACCIOLA, OSBORNE, SEIL* First Set of Admissions #39(2).)

3) Galactorrhea (D-*GOLDBARG* First Set of Admissions #39(3).)

4) Dystonia (D-*KAHN, KANTAR, MALAMUD, SCHILDKROUT, SIEGEL, SZLYK, TURNQUEST, GILL, GOODMAN, GOLDBARG, CACCIOLA, OSBORNE, SEIL* First Set of Admissions #39(4).)

5) Chorea D-*POMERANTZ, GOLDBARG, CACCIOLA* First Set of Admissions #39(5).)

6) Nausea (D-*POMERANTZ* First Set of Admissions #39(8).)

7) Drowsiness (D-*POMERANTZ* First Set of Admissions #39(9).)

8) Impotency (D-*MAZMANIAN, POMERANTZ, SZLYK, TURNQUEST, GOODMAN, GOLDBARG, CACCIOLA, OSBORNE* First Set of Admissions #39(10).)

9) Photosensitivity (D-*POMERANTZ, GOLDBARG, CACCIOLA, OSBORNE* First Set of Admissions #39(11).)

10) Effect of motor skills (D-*POMERANTZ, SCHILDKROUT, SZLYK, CACCIOLA, OSBORNE* First Set of Admissions #39(12).)

11) Effect on ability to concentrate, clouds mind (D-*POMERANTZ, OSBORNE* First Set of Admissions #39(13).)

12) Effect on mood, personality (D-*POMERANTZ, OSBORNE* First Set of Admissions #39(14).)

13) Dry mouth (D-*GOODMAN, GOLDBARG, CACCIOLA, OSBORNE, SEIL* First Set of Admissions #39 (15).)

14) Blurred vision (D-*MAZMANIAN, POMERANTZ, SZLYK, TURNQUEST, GOODMAN, CACCIOLA, GOLDBARG, OSBORNE* First Set of Admissions #39(16).)

15) Motor restlessness (D-*MAZMANIAN, POMERANTZ, SCHILDKROUT, TURNQUEST, GOODMAN, GOLDBARG, CACCIOLA, OSBORNE* First Set of Admissions #39(17).) (See also, Stip. pp. 356, 357.)

DR-94.) (1-15) None of the doctors admitted that "many" members of the plaintiff class suffered from any of these symptoms.

(5) None of the three doctors cited in support of this finding have admitted that any of their patients suffered from chorea induced by medication. All have in fact denied this. (Dr. Pomerantz, Dr. Goldbarg, Dr. Cacciola, First Set of Admissions ¶39(5).)

(8) Drs. Mazmanian, Turnquest and Szlyk denied that any of their patients had had side-effects of impotence caused by medication. (First set of Admissions ¶39(10).)

(9) Dr. Goldbarg denied that any of his patients had had side-effects of photosensitivity caused by medication.

(1) Drs. Schildkrout and Szlyk denied that medication had caused side-effects upon motor skills. At any rate, none of the defendants admitted that the side effects of the medication upon motor skills were adverse. (First Request for Admission ¶39(1)).

(11) See Defendants' Response to Plaintiffs' Proposed Finding (Medication — General)¶93.

(12) See Defendants' Response to Plaintiffs' Proposed Finding (Medication — General)¶92.

(13) The requests for admission did not indicate that dry mouth was a long-lasting symptom. Dr. Seil specifically stated that the symptom usually goes away.

(14) Dr. Szlyk denied that medication had caused blurred vision among his patients. None of the admissions indicated blurred vision was a permanent or long-lasting effect of medication.

(15) Dr. Turnquest denied that medication has caused side-effects of motor restlessness in any of her patients.

95.) Some patients of the plaintiff class who have received PRN medication prescribed by a physician have complained of the following adverse side effects:

1. Parkinsonism

2. Dystonia
3. Drowsiness
4. Effects on motor skills
5. Dry mouth
6. Blurred vision

Statement of Agreed Facts for Injunctive Relief #32. (Stip. p. 357.)

96.) Some patients of the plaintiff class who have received PRN medication prescribed by a physician have incurred the following objectively verifiable side effects:

1. Parkinsonism
2. Dystonia
3. Drowsiness
4. Dry mouth
5. Blurred vision

Statement of Agreed Facts for Injunctive Relief #33. Stipulations, page 357.

97.) The named plaintiffs have been subjected to the following side effects as a result of being administered antipsychotic drugs:

a) *Tardive dyskinesia*
   (1) DONNA HUNT
   (Doc. Nos. 100492, dated 6/24/74, 101931, 101901, A 101519. TR. 18-138,139,140, P-Kauff TR. 18-123-151.)

b) *Akinesia*
   (1) *RUBY ROGERS*
   (P-Messinger TR. 31-78.)
   (2) *DONNA HUNT*
   (D-*SZLYK* TR. 6-14, lines 19-24; 6-55, lines 18-24.)

c) *Akathisia*
   (1) *RUBY ROGERS*
   (P-Messinger TR. 31-76,77,78. Doc. No. 500031. P-*ROGERS* TR. 28-16.)

d) Adverse effect on thinking: slowing the thought processes and clouding the mind

(1) *BETTY BYBEL*

(P-Cariello TR. 22-13,17. P-Messinger TR. 32-27,38. P-Franceen TR. 20-45,46. P-*BYBEL* TR. 39-14, lines 7-17.)

(2) *WILLIE WADSWORTH*

(P-Keller TR. 28-83,84.)

(3) *HAROLD WARNER*

(P-*WARNER* TR. 37-68, lines 19-22; 37-57, lines 1-12.)

e. *Adverse effect on learning*

(1) *DONNA HUNT*

(P-KAUFF TR. 18-150, lines 18-25; 18-151, lines 1-7.)

f) *Behavioral toxicity*

(1) *ABLE BOLDEN*

(P-Whitaker TR. 34-110, lines 14-18; 38-35, 36.)

g) *Pseudo parkinsonism*

(1)*HAROLD WARNER*

(P-*WARNER* TR. 37-68, lines 19-22; 37-57, lines 1-12; 37-84.)

(2) *RUBY ROGERS*

(Doc. No. 500031. P-*ROGERS* TR. 28-12,13,14,16)

(3) *DONNA HUNT*

(D-*SZLYK* TR. 6-14, lines 14-25; 6-15, line 1; 6-55, lines 18-25.)

h) *Over sedation*

(1) *BETTY BYBEL*

(P-Messinger TR. 32-37,38. P-Cariello Tr. 22-17,18, 19,20,21,22. P-Franceen TR. 20-50. D-*KANTAR* TR. 14-38,39. P-*BYBEL* TR. 39-14, lines 7-17. Doc. No. 300209, dated 1/28/74.)

(2) *RUBY ROGERS*

P-Messinger TR. 31-78. Doc. No. 500018.)

(3) *DONNA HUNT*

(P-Kauff TR. 18-79, lines 17-23. P-Demers TR. 1-128, lines 18-25; 1-129, lines 1-3. Doc. No. 100116.)

i) *Neutropenia* (low white blood count that makes it difficult for body to protect against bacterial infection)

(1) *RUBY ROGERS*

(P-Messinger TR. 31-84,85,86,87.)

j) *Dysphoria*

(1) *RUBY ROGERS*

(P-Messinger TR. 31-56,57. P-*ROGERS* TR. 28-8,9,10,14,15.)

k) *Adverse effects on motor skills*

(1) *BETTY BYBEL*

(P-Franceen TR. 20-50.)

l) *Reduce assertiveness and increase conformity*

(1) *BETTY BYBEL*

(D-*KANTAR* TR. 14-37, lines 15-25; 14-38,39.)

m) *Adverse reaction to drugs based on the personality of the patient*

(1) *WILLIE WADSWORTH*

(P-Whitaker Tr. 33-27,28.)

DR-97m.) There is nothing in the cite to this finding to suggest that Willie Wadsworth had an adverse reaction to drugs based on his personality.

(IV.) WHY PATIENTS REFUSE ANTIPSYCHOTIC DRUGS

PATIENTS REFUSE ANTIPSYCHOTIC DRUGS FOR THE FOLLOWING REASONS:

98.) Patients find extrapyramidal symptoms unbearable. (P-"Van Putten — Why Do Schizophrenic Patients Refuse" TR. 34-20, lines 5-25; 34-21, line 1; 38-46, lines 24-25; 38-47, lines 1-4. P-"Van Putten and Crumpton" TR. 34-24, lines 13-23; 34-26, lines 8-9.)

DR-98-109.) See Defendants' Proposed Findings of Fact, J-264-274.

DR-98.) Side effects are emotionally painful and frightening only if not properly explained to the patient. Tr. 57 at 136 (Brill).

99.) There is no uniformity in the criteria for assessing the presence or absence of extrapyramidal effects, and the subtler extrapyramidal symptoms often go unrecognized by the physician — but not by the patient! Even mild extrapyramidal involvement can be unbearable and lead to outright drug reluctance or self-prescribed reduction or dosage. (See Proposed Finding #98. P-Whitaker TR. 34-20, lines 5-25; 34-21, lines 1-19. P-*ROGERS* TR. 28-8,9,10,11,12,13,14,15,16. P-DiMascio TR. 37-9, lines 21-25. D-*SEIL* TR. 58-96. P-Whitaker TR. 34-18, lines 21-25; 34-19, lines 1-14. D-*SZLYK* TR. 6-13, lines 16-25; 6-14, lines 1-5.)

DR-99.) Dr. DiMascio said only that akathisia is one of the side-effects for which patients have refused medication. He did not suggest that akathisia is "unbearable". Tr. 37 at 9 (DiMascio). Dr. Szlyk said nothing to suggest this finding, Tr. 6 at 13, 14, was a discussion of the prophylactic use of antiparkinson agents. Dr. Seil said nothing but that Rubie Rogers had built up an antipathy to Haldol. Tr. 58 at 96 (Seil).

DR-99, 101, 104, 106, 108.) Although Dr. Whitaker claimed that the literature supported him, he was unable to cite any literature to support his conclusion regarding the reasons why patients refuse medication other than the two VanPutten articles, which do not support his conclusions.

100.) Patients refuse antipsychotics because they are responding to disquieting symptoms such as drooling, very poor coordination, extreme dryness of the mouth, extrapyramidal symptoms, and myriad other symptoms which have been reported in the literature to be commonly associated with antipsychotic drugs. (P-Whitaker TR. 34-19, lines 15-25. D-*SZLYK* TR. 6-13, lines 16-25; 6-14, lines 1-5; 6-11, lines 10-20.)

DR-100.) Dr. Szlyk said nothing to suggest this finding. Tr. 6 at 13, 14 was a discussion of the prophylactic use of antiparkinson agents.

101.) There are physiological reactions — reducation in response time, sometimes coordination, so forth — which patients find uncomfortable and objectionable. (P-Whitaker TR. 34 -19, lines 1-5.)

102.) Patients react adversely to the sedative effects of the drugs. (P-"Van Putten, Crumpton, Yale" TR. 34-24, lines 13-18; 34-25, lines 23-25. P-"Van Putten" TR. 38-46, lines 7-10.)

103.) Other patients refuse because they experience dysphoric responses to the neuroleptic drugs; feelings of psychological distress and discomfort; feeling "drugged", having "no drive or ambition", being "drowsy", "bored" or "slowed up." (P-"Van Putten and May" TR. 34-21, lines 22-25; 34-22, lines 1-6; 34-23, lines 9-25; 34-24, lines 1-13.)

104.) Some patients resist the drugs because they desire to be in complete control of their lives and view the drugs as an external dominating agent. (P-"Van Putten" TR. 28-45, lines 17-25; 38-46, lines 1-6; 11-16. P-Whitaker TR. 34-19, lines 6-14. P-DiMascio TR. 29-33, lines 4-25; 29-34, lines 1-13.)

DR-104.) Dr. DiMascio did not discuss reasons why patients refuse drugs on the page cited in this finding. Tr. 29 at 33, 34 (DiMascio).

105.) Sarwer-Foner, a pioneer in the dynamic aspects of drug response, has emphasized that the sedative, extrapyramidal, or other psychologic effects of antipsychotic drugs can precipitate panic reactions, further psychotic deterioration, and increased somatization, thereby causing patients to refuse drugs. (P-"Van Putten" TR. 38-45, lines 17-25; 38-46, lines 17-25.)

106.) There are certain patients with certain personality types who respond negatively to the marked sedative-motor inhibiting effects of antipsychotics. Those patients want to be

active and in control of their lives and feel the antipsychotics lessen their ability to be active and in control of their life. (P-Whitaker TR. 38-47, lines 16-25; 38-46, lines 1-8; 34-19, lines 6-14. P-DiMascio TR. 29-33, lines 4-25; 29-34, lines 1-13.)

DR-106.) Regarding the first sentence of this statement, Dr. DiMascio was discussing the work of Dr. Sawyer-Foner. Dr. DiMascio said nothing to suggest the second sentence of this finding. (Dr. DiMascio, Tr. 29 at 33, 34).

107.) Some hard-core drug-refusors experienced and seem to prefer a resurgence of a grandiose psychosis shortly after they stop their medication, rather than the depression and anxiety characteristic of the less frequent decompensations of a group of chronic schizophrenics who took their medications faithfully. Grandiosity was associated with maintenance drug-refusal and the dysphoric affects of depression and anxiety are characteristic of drug-compliers. (P-"Van Putten, Crumpton and Yale" TR. 34-24, lines 13-23; 34-26, lines 10-25; 34-27, lines 6-16.)

108.) Often patients refuse because they are recognizing the long-term consequences of heavy and prolonged use of antipsychotic drugs, in producing such disorders as tardive dyskinesia which is generally thought to be irreversible. (P-Whitaker TR. 34-19, lines 24-25; 34-20, lines 1-4.)

109.) Often times refusal of medication is connected with the fear that the medication will be very harmful to the patient. (D-Green TR. 61-54, lines 5-9.)

DR-109.) Ms. Burke-Green clearly indicates that the fears of the patients that the medication is harmful are irrational, and that she would try to convince the patient of the fact that the medication was helpful. Tr. 61 at 54 (Burke-Green).

(V.) THE BENEFITS OF ANTIPSYCHOTIC DRUGS HAVE BEEN EXAGGERATED

(A.) *Effectiveness of Antipsychotic Drugs*

110.) In a mental hospital institution anywhere from 75-85 percent of the patients are on a psychotropic drugs. This is based on the reviews that was carried out at various institutions. (P-DiMascio TR. 29-48, lines 21-25.)

111.) Major drug studies have shown that, at most, 50 percent of schizophrenics derive some benefit from neuroleptics. (P-"Crane- Two Decades" TR. 37-27, lines 22-25; 37-28, lines 1-3. P-DiMascio TR. 37-44, lines 10-25; 37-45, lines 1-4.)

DR-111&112.) These studies deal only with maintenance dosages of medication. The studies show that maintenance drugs do not help everyone. They also show that many more patients are helped by maintenance dosages than patients who are not on maintenance dosages. Since it is not yet possible to know in advance which are the patients who do not need the medication, the studies have concluded that additional research is necessary to help determine what type of patients will benefit from the medication. Meantime, given the fact that a patient has a better chance of remaining non-psychotic on drugs, rather than off drugs, the studies conclude that it is better to keep the patients on maintenance drugs. See Defendants' Proposed Findings of Fact, J-212, 214, 153, 167, 169, 170, 171, 177, 178.

112.) Fifty percent of patients on maintenance dosages of antipsychotic drugs do not need nor should be on maintenance drugs. (P-"Gardos and Cole" TR. 37-27, lines 9-21. P-DiMascio Tr. 37-27, lines 9-21; 37-49, lines 10-22.)

113.) It has generally been stated that antipsychotic medications do not cure a psychosis. (P-DiMascio TR. 29-56, lines 8-15.)

DR-113.) See Defendants' Proposed Findings, J-180-182.

114.) Antipsychotic medication is not a cure for schizophrenic thinking, it just reduces the symptoms. (P-DiMascio TR. 35-86, lines 3-6. P-Whitaker TR. 33-89, lines 21-24.)

DR-114.) Antipsychotic medications actually reduce anxiety, tension and hostility and not merely the symptoms of anxiety, tension and hostility, TR. 57 at 13-14 (Brill).

115.) Antipsychotic medications have a limited effect. They reduce hallucinations, delusions and behavior disorder. But in many cases, especially the long-term cases, they leave a burned-out situation. They do not return to the patient the normal spontaneity so that we have the effects of chronic, long-term schizophrenia without the secondary effects of delusions, hallucinations and behavior disorder. In some cases we have managed to wipe away only the secondary and vivid symptoms and we have left the defect because these drugs do not hit the other side of the illness, the defect side, the loss. And that type of loss has been described for 200 years in schizophrenic-type patients. (D-Brill Tr. 57-141, lines 21-25; 57-142, lines 1-13.)

DR-115.) Many patients before the introduction of antipsychotic drugs lost their drive and initiative and became what has been termed "burned out." Tr. 61 at 40-41 (Brill). While antipsychotic medications may leave a burned out schizophrenic, it is the illness of schizophrenia and not the antipsychotic medications that cause the patient to be burned out. Tr. 61 at 41 (Brill). The use of antipsychotic medications on an acute psychotic schizophrenic patient cannot leave that patient burned out. Tr. 61 at 41 (Brill).

116.) The distinctive value of the drugs may well be limited in most instances to their capacity to alleviate the distress of acute emotional decompensation. (P-"Bochoven and Solomon", P. DiMascio, TR. 37-22, lines 8-25; 37-23, lines 1-12; 61-27, lines 15-19. D-Brill TR. 61-24, lines 17-25; 61-25, lines 1-5.)

DR-116.) The number of patients studied by Solomon and Bochoven do not justify sweeping generalizations. Tr. 61 at 29 (Brill).

Dr. Brill did not agree with the conclusion of the Bochoven and Solomon article that the distinctive value of the drugs may well be limited in most instances, to their capacity to alleviate the distress of acute emotional decompensation. In fact, Dr. Brill specifically refused to agree or disagree with the statement because the language of the article is carefully hedged, its conclusions were only suggested, and the numbers of the patients in the study is insufficient to support such a generalization. Tr. 61 at 29 (Brill). Dr. DiMascio never agreed with the statements made in the Bochoven and Solomon article. Tr. 37 at 22, 23 (DiMascio).

117.) Long-term studies of patients treated by antipsychotics are not available. (P-"Crane - Two Decades" TR 37-27, lines 22-25; 37-29, lines 7-9. P-DiMascio TR. 37-47, lines 23-25; 37-48, lines 1-7.)

DR-117.) (1) The extent and seriousness of long-term risks of the use of antipsychotic drugs is pretty well understood, as statistical and empirical studies have been conducted since 1955. Tr. 57 at 21 (Brill).

(2) Five and ten year studies of drug treated patients are available. Tr. 57 at 71 (Brill).

(3) While it may not be known if the massive use of neuroleptics can reduce or delay progressive mental incapacitation, the gaining of five or ten or fifteen or twenty years of useful life for an individual in itself is a worthwhile goal, even if one still does not know how it will end up after that time. Tr. 57 at 72 (Brill).

(4) There is sufficient information to compare the final outcome of psychosis before and after the psychopharmacology era. Tr. 37 at 48-49 (DiMascio).

(5) Dr. DiMascio did not agree that long term studies of drug-treated patients are not available. In fact, he specifically said that it depended on how one defined the "long term". He said that five-year follow-ups have indeed been done. Tr. 37 at 48 (DiMascio).

118.) The excessive reliance on these drugs has obscured their limitations and created a superimposed set of formidable treatment problems (P-"Caffey - Symposium" TR 33-102, lines 22-25; 33-103, lines 8-10.)

119.) To understand the limitations of antipsychotics, it is essential that some clarification be given concerning the interpretation of results in studies attesting to their efficacy. (P-"Caffey - Symposium" TR. 33-102, lines 22-25; 33-103, lines 10-14; 33-103.)

120.) The consistent findings that antipsychotic drugs produce statistically significantly better results than placebo or psycho-therapy does not imply that all patients receiving these drugs respond well or even optimally to them. The results simply indicate that patients as a group do better than comparable groups receiving some other type of treatment. Conversely, it also frequently happens that many patients in the controlled group demonstrate varying degrees of improvement over time without any active medication. (P-"Caffey - Symposium" TR. 33-102, lines 22-25; 33-103, lines 15-25.)

121.) Improvement on antipsychotic drugs does not mean that this change is sufficient to insure discharge from the hospital or guarantee adequate functioning in the community. Although psychopathology may diminish, many patients start at such a low level of socially adaptive behavior that subsequent improvement represents only a fraction of the amount necessary to alter their prognosis. It should be emphasized that statistical improvement on a group of patients is not synonomous with substantial clinical improvement of individual patients. (P-"Caffey - Symposium" TR. 33-102, lines 22-25; 33-104, lines 1-13.)

DR-121-122.) Statistical improvement studies for antipsychotic medications have taken into account the degree and extent of improvement of the patient and the length of time the patient remains improved. Tr. 57 at 29 (Brill).

122.) Improvement on drugs may simply indicate that patients are more manageable and tractable in the hospital, and assume the patient role better than previously, but may not indicate that they have become more socially responsible and self-sufficient human beings. (P-"Caffey-Symposium" TR. 33-102, lines 22-25; 33-104, lines 12-17.)

123.) Perhaps one of the most practical limitations of phenothiazines or other psychotropic drugs is that discharging these patients on the drugs does not automatically insure that patients will continue taking these drugs. (P-"Caffey - Symposium" TR. 33-102, lines 22-25; 33-104, lines 18-22.)

124.) Those who do improve do not show anything approaching a recovery from the disease. (P-"Crane - Two Decades" TR. 37-27, lines 22-25; 37-28, lines 3-5. P-"Caffey - Symposium" TR. 33-102, lines 22-25; 33-104, lines 1-13.)

DR-124.) Those who improve on medications can completely recover from their disease. Tr. 37 at 45 (DiMascio). See also Defendants' Proposed Findings of Fact, J-155, 158, 169, 174, 175, 177, 180-210.

(B.) *Relapse Rates*

125.) The superiority of drugs over placebo may be somewhat higher when social therapy is provided and when one makes allowances for the failure of certain patients to adhere to the prescribed drug regime. However, the difference between those patients treated with drugs and those not treated with drugs decreases over time. According to one study, the difference may be only on the order of 10 to 15 percent after several years. (P-"Crane-Clinical Psychopharmacology" Tr. 37-30, lines 22-25; 37-31, lines 1-8.)

DR-125.) While it may be true that the difference between those treated with drugs and those not treated with drugs decreases over time, over time there is still a difference in favor of drug treated patients. In addition, the drug treated patients are healthy, while the time is passing. Tr. 57 at 73 (Brill).

126.) A considerable percentage of patients relapse despite the

continued use of drugs. (P-"Crane - Two Decades" Tr. 37-27, lines 22-25; 37-28, lines 6-8. P-DiMascio TR. 37-45, lines 14-19.)

127.) As to the quality of the patient's adjustment after he leaves the hospital the results of drug therapy are even less encouraging: the majority of those who live in the community continue to be unproductive and are often a burden to their families. (P-"Crane - Clinical Psychopharmacology" TR. 61-44, lines 10-25; 61-45, lines 21-25; 61-46, lines 1-3. P-Whitaker TR. 33-115, lines 20-25; 33-116, lines 1-10.)

DR-127.) Patients treated on antipsychotic medication can become quite productive in the community. Tr. 57 at 51 (Brill).

128.) Individuals released in foster homes or to other sheltered environments may be as dependent and alienated as those confined to an institution. (P-"Crane - Clinical Psychopharmacology" TR. 61-44, lines 10-25; 61-46, lines 4-6. P-Whitaker TR. 33-115, lines 20-25; 33-116, lines 1-10.)

129.) The fear has been expressed that the decline in the number of patients in public health hospitals is only a statistical artifact, and not a true gain. Whereas hospitalized patients were formerly living lives of quiet desperation as chronic patients in mental institutions, similar patterns of chronic illness and social impairment are being lived by these patients in nursing homes in the case of the aged or in rooming houses and other marginal residential facilities in the case of chronic psychiatric patients. The effectiveness of the psychotropic drugs has contributed to these trends since the available agents, particularly the antipsychotic drugs, ameliorate the patients' several disturbances, particularly their psychotic thinking, sufficiently so as to allow discharge into the community. But the patients are left emotionally blunted, occupationally impaired and socially isolated. (P-"Klerman - Psychotropic Agents" TR. 57-140, lines 1-6, 20-25; 57-141, lines 1-18. D-Brill TR. 57-140, lines 1-6, 20-25;

57-141; 57-142, lines 1-13. See also P-Whitaker TR. 33-115, lines 20-25; 33-116, lines 1-10.)

DR-129.) See Defendants' Response to Plaintiffs' Proposed Finding (Medication - General), #117.

130.) Antipsychotic medication may make some schizophrenic patients more vulnerable to future relapse than would be the case in a natural course of their illness. (P-"Carpenter, McGlashan and Strauss" TR. 33-99, lines 7-14. P-Whitaker TR. 33-116, lines 11-25; 33-117, lines 1-4.)

DR-130.) Carpenter, McGlashan and Strauss' statements that drugs may make some patients more vulnerable to future relapse than if they received no drug treatment and drugs may be exacting a price in terms of future rigidity in their article "The Treatment of Acute Schizophrenia Without Drugs: An Investigation of Some Current Assumptions", are pure speculation unsupported by their own research or any other study. Tr. 36 at 83/84-86 (Carpenter, McGlashan, Strauss, "The Treatment of Acute Schizophrenia Without Drugs: An Investigation of Some Current Assumptions", p.19). See also Defendants' Proposed Finding J-215.

131.) If the goal of the drug treatment is to make the person fit into a very limited kind of living situation such as a hospital or half-way house, then drug treatment used almost exclusively may be the treatment of choice — but if the choice is to help the patient develop the ability to function independently and adaptably outside the hospital; to deal with the patient's full emotional expression and full capacities then drug treatment is not the treatment of choice. (P-Whitaker TR. 33-98, lines 4-19; 33-96, lines 20-25; 33-97, lines 1-3.)

DR-131.) See Defendants' Proposed Findings J-152-179.

132.) In addition, insofar as the psychotic break contains potential for helping the patient alter pathological conflicts within himself and establish a more adaptive equilibrium with his environment, our present-day practice of immediate and massive pharmocological intervention may be enacting a price

in terms of patients with greater rigidity of character structures who are less able to cope with subsequent life stresses. (P-"Carpenter, McGlashan and Strauss" TR. 33-99, lines 7-24. P-Whitaker TR. 33-99, lines 7-25; 33-100, line 1.)

DR-132.) Antipsychotic medication does not cause a rigidification of personality. Tr. 57 at 66, 67 (Brill).

(C.) *Antipsychotic Drugs and its effects on Deinstitutionalization*

133.) What happened was during the first years, 1955, '56, even '57, there was no real change in institution operating practices, but beginning in about 1960, 1961, administrators and legal changes began to take place and these changes have progressively accelerated the speed of deinstitutionalization from a rate of about less than 1 percent a year to as high as 10 or 15 percent a year, and in some cases, by administrative action, to virtually closing the state service of this type. (D-Brill TR. 61-23, lines 14-25.)

DR-133-136.) Deinstitutionalization at a rate of one percent per year must be compared to an increase in hospital population before the drug era. See generally Defendants' Proposed Findings of Fact J-217-225. See specifically Defendants' Proposed Finding J-220.

134.) Probably the most important explanation for the erosion of the hospital system is the administrators' failure to solve a number of chronic problems, such as inadequate staffing, low morale of the personnel, and substandard psychiatric care of the mentally ill. These conditions are often deplored but seldom remedied. Lately, political pressure groups and civil liberty organizations have created serious legal difficulties concerning the patients' admission and confinement in institutions and, thus, have imposed a new burden on the hospital staff. Faced with these insoluble problems, hospital administrators and heads of mental health departments welcomed a program emphasizing care of the mentally ill in the community. (P-"Crane - Two Decades" TR. 37-18, lines 6-11; 37-21, lines 2-23. P-Whitaker TR. 33-114, 33-115.)

135.) The factors that accelerated deinstitutionalization were administrative policies, legal moves with respect to patient's rights, and a general climate of opinion that given everything that we had in the way of treatment, that institutionalized care was far less necessary than it had been before. (D—Brill TR. 61-23, lines 4-25; 61-24, lines 1-6. See also "Crane - Two Decades" TR. 37-18, lines 6-25; 37-21, lines 2-23.)

136.) Patients are now being 'locked out' of hospitals as firmly as they were 'locked in' hospitals only a few years ago. (P—"Crane - Two Decades" TR. 37-18, lines 6-11; 37-19, lines 20-25; 37-20, line 1.)

137.) At this point, it difficult to determine how much the therapeutic effectiveness of drugs and how much a change in policy of mental health care contributed to the patients' exodus from state hospitals. (P—"Crane - Two Decades" TR. 37-18, lines 6-11; 37-19, lines 11-18. P—Whitaker TR. 33-114; 33-115. See Proposed Finding #133-136.)

DR-137.) See Defendants' Proposed Findings J-218, 220.

(D.) *The need for antipsychotics have been exaggerated*

138.) Psycho-tropic drugs may not be indispensible to the success of community-based mental health services and that their extended use in aftercare may prolong the social dependency of many discharged patients. (P—DiMascio; P—"Bochoven and Solomon" TR. 37-22, lines 8-25; 37-23, lines 1-12; 37-23, lines 14-25; 37-24, lines 2-7, 37-25, lines 10-16. D—Brill TR. 61-24, lines 17-24; 61-25, lines 1-5. P—Whitaker TR. 33-114; 33-115.)

DR-138-140.) (1) Dr. DiMascio did not agree with these findings but only said that the author of the article was authoratative. Tr. 37 at 23 (DiMascio). Dr. Brill did not make these statement, and in fact, specifically refused to agree with Bochoven and Solomon. Tr. 61 at 29, lines 14-25).

(2) The data in the Bochoven & Solomon article does not support the proposition that the widespread use of antipsychotic drugs has not dramatically reduced the state hospital popula-

tion and the duration of hospital stays. Tr. 64 at 63-64 (Gill).
(3) Bochoven and Solomon compared a follow up group of patients who had been hospitalized in 1947 to a follow up group of patients who had been hospitalized in 1967. The two groups of patients were not comparable. The 1947 group contained more patients who were not being readmitted to a mental hospital. Tr. 64 at 68-69 (Gill).
(4) Even Bochoven and Solomon's data show that psychiatric patients hospitalized before the introduction of antipsychotic drugs were hospitalized for longer periods of time, were more likely to die, and were less likely to remain in the community than patients hospitalized after the introduction of antipsychotic drugs. Tr. 64 at 64-69 (Gill) (Bochoven and Solomon, p. 796, 797).
(5) Bochoven and Solomon specifically admit that one factor that may explain the reduction in time spent in mental hospitals by the post-drug era patients is the use of psychotropic drugs. Tr. 64 at 68 (Bochoven & Solomon, p.797).
(6) Many of the patients who did get better before the introduction of drugs underwent more restrictive forms of treatment such as shock therapy. Tr. 64 at 69 (Gill).
139.) One of the co-authors of the Bochoven Solomon study, Dr. Solomon, is a former Commissioner of the Massachusetts Department of Mental Health. (D—Brill TR. 61-24, lines 17-24, 61-25, lines 1-5.)
140.) The finding of no substantial change in schizophrenic patients was not expected in view of the absence of psychotropic drugs during the entire five years of the Boston Psychopathic Hospital follow-up period, compared with the extensive use of the psychotropic drugs at Solomon Center for both initial treatment on admission and the entire period of after care. This finding suggests that the attitudes of personnel toward patients, the socio-environmental setting and community helpfulness, guided by citizen organizations may be

more important in tipping the balance in favor of social recovery than are psychotropic drugs. (P—DiMascio; P—"Bochoven and Solomon" TR. 37 -22, lines 8-25; 37-23, lines 1-12; 61-25, lines 22-25; 61-26, lines 22-25; 61-27, lines 1-14. D—Brill TR. 61-24, lines 17-25; 61-25, lines 1-5. See also P—"Carpenter, McGlashan and Strauss" TR. 36-87. P—Whitaker TR. 33-114,115.)

141.) A progressive social environment, with a broad range of non-drug treatments substantially reduces or eliminates the need for antipsychotic drugs for most patients. (P—"Carpenter, McGlashan and Strauss" TR. 33-109, lines 22-25; 33-110, lines 1-6. P—"Paul, Tobias and Holly" TR. 33-110, lines 14-25; 33-111, line 1; 33-113; 33-114, lines 1-3. P—"Mendel" TR. 33-11 lines 15-25; 33-112, lines 1-7. P—Whitaker TR. 3 lines 15-25; 33-112; 33-113; 33-114; 33-115.)

DR-141.) (1) The controls in the Carpenter, McGlashon and Struass study "The Treatment of Acute Schizophrenia Without Drugs" are enormously weak. Tr. 60 at 134 (Kahn).

(2) The ability of the staff in the Carpenter, McGlashon and Strauss study to attempt to treat the subject patients without drugs was no doubt facilitated by the unit's small size (11 beds) and ample staff. The average staffing pattern included three psychiatrists (with both clinical and research responsibilities), one social worker, one half-time activities worker, and 13 nurses and nursing assistants divided among three shifts, seven days a week. Tr. 60 at 134 (Carpenter, McGlashon and Strauss, p.17).

(3) In the Carpenter, McGlashon and Strauss study, the use of medication was prescribed only during the research drying-out period; otherwise, the patient's doctor could elect to use drugs, although emphasis was always on psychological treatment. Tr. 60 at 135 (Carpenter, McGlashon and Strauss, p.17).

(4) After discharge testing, the patients in the Carpenter,

McGlashon and Strauss study were hospitalized, as necessary, for two weeks to permit re-institution of medication and re-integration into the community. Tr. 60 at 135 (Carpenter, McGlashon and Strauss, p.16).

(5) The premise of the Carpenter, McGlashon and Strauss study was that psychopharmacology is pre-eminent in the treatment of schizophrenic patients and that a great many members of the psychiatric profession consider that failure to use medication in acute schizophrenic patients is unethical at worst or poor clinical judgment at best. Tr. 60 at 135, 136 (Carpenter, McGlashon and Strauss, pp. 14 and 18).

(6) While Dr. Whitaker testified that the Mendel article, "Tranquilizer Prescribing as a Function of the Experience and Availability of the Therapist" was authorative, Dr. Whitaker possibly did not even read the article until Mr. Cole showed it to him and could not even recall why he called the article authoritative. Tr. 36 at 36-37 (Whitaker).

(7) While Mendel concluded that many patients do not require medication, he did so in the context of a ward staffed by at least twelve psychitatrically trained professionals treating only twenty-five patients. Tr. 36 at 81-83/84 (Mendel, "Tranquilizer Prescribing as a Function of the Experience and Availability of the Therapist", p.55, 59).

(8) Mendel, in fact, concludes that the ideal situations is one in which psychotherapy is aided by the proper use of medication. Tr. 36 at 83/84 [Mendel, *ibid*], p.59).

(9) The Paul, Tobias review of studies on the effectiveness of antipsychotic medication is substantially fallacious, as Tobias compares ineffective doses with no drug, which is not a meaningful comparison. Tr. 35 at 102-105 (Davis, "Overview: Maintenance Therapy in Psychiatry: 1. Schizophrenia", Am. J. of Psych., Vol 132, Dec. 1977, p.1240).

(10) The method of analysis employed by Paul and Tobias was "reductio ad absurdum." Tr. 35 at 110 (Gardos and Cole, "Maintenance Antipsychotic Therapy: For Whom and For

How Long", in Lipton, DiMascio & Killam (ed), *Psychopharmacology, A Generation of Progress*, pp. 1169-1170.

(11) The Paul, Tobias and Holly article is not an authoritative text. The authors are not known nationally. In fact, the major author was doing his master's thesis and was not an expert on medication. None of the authors were M.D.s. Tr. 64 at 69, 70 (Gill).

(12) The Paul, Tobias and Holly article does not discuss the effectiveness of drugs on acute schizophrenic patients. Tr. 64 at 70 (Gill).

(13) Tobias presents his findings in a misleading manner and his conclusions are incorrect. Most of his criticisms are either wrong or trivial. Any error in prior studies concluding that antipsychotics prevent drug relapse err in the direction of understating the effectiveness of the drugs. Tr. 64 at 70-78 (Gill) (Davis, John, "Maintenance Antipsychotic Drugs Do Prevent Relapse: A Reply to Tobias & McDonald", Vol. 83, No. 3, *Psychol. Bull* (1976), pp. 431, 432, 437, 438, 441, 443, 444.)

(VI.) LEGAL CONDITIONS UNDER WHICH A PATIENT MAY BE ADMITTED TO THE BOSTON STATE HOSPITAL

142.) Most patients are admitted under one of the following conditions:

1. Conditional Voluntary Admission (Section 10 and 11).
2. An Involuntary Temporary Hospitalization (10-day paper, Section 12).
3. Involuntary Prolonged Civil Commitment (Section 7 and 8).
4. Commitment of an Alleged Alcoholic (Section 35).
5. Admission and Retention of the Mentally Retarded.

Stipulations, Admission packet, pages 3 and 4, Stip. pp. 27, 28.

143.) *Conditional Voluntary Admission (Section 10 and 11).* Most patients are encouraged to apply to the institution on a voluntary basis. Anyone 14 years or older may apply for in-

patient or out-patient care and treatment for mental illness or mental retardation at this facility. Parental or guardian consent to the application is not necessary if the applicant is 16 years or older. In addition, a parent or guardian may apply on behalf of a person under 21. If a patient is admitted on a conditional Voluntary Admission, he may be discharged after he has given a three-day notice to his caretaking physician. The prospective patient may inspect and view the living quarters if he wishes. Stipulation, at page 27. Admission packet at page 3, 4.

144.) *Involuntary Temporary Hospitalization (10-day paper) (Section 12).* A patient may be admitted under this paper if a qualified physician decides that failure to hospitalize the person would create a likelihood of serious harm by reason of mental illness. Following the 10-day examination, if it is decided that failure to hospitalize the patient further would create a likelihood of serious harm by reason of mental illness, then the hospital may make a petition for civil commitment to the facility. This petition is made to a court and a hearing will be held if a patient or patient's relatives request one. If the patient or patient's relatives do not request a hearing, the court will act on the basis of the petition. The court may then order the patient committed for a period up to one year. The first order of commitment under this section will be valid for six months. Stipulations at pages 27, 28; admission packet at page 3, 4.

145.) *Involuntary Prolonged Civil Commitment (Sections 7 and 8).* The Superintendent of this hospital may petition the district court for the commitment of any patient at the hospital if it has been determined by the Superintendent that failure to hospitalize the patient would create a likelihood of serious harm by reason of mental illness. After receiving the Superintendent's request, the court will notify the patient and the patient's nearest relative or guardian. A hearing will be held if the patient requests one. The court may then order the

patient committed for a period of up to one year. The first order will be valid for six months. Stipulations at page 28, Admission packet at page 3, 4.

146.) *Commitment of an Alleged Alcoholic (Section 35).* A police officer or a physician may, by written petition to any district court, seek an order of due commitment of a person he has reason to believe is an alcoholic. If the court finds that the person is an alcoholic and that there is likelihood of serious harm because of his alcoholism, the court may order the person committed for a period of up to 15 days. The person may be released before the expiration of the period of commitment if the Superintendent decides that his release will not result in the likelihood of serious harm. Stipulations at page 28, Admission packet page 3, 4.

147.) *Admission and Retention of the Mentally Retarded.* All admissions of the mentally retarded shall be voluntary. After admission, mentally retarded persons may be retained involuntarily only if they are also mentally ill and their release would create a likelihood of serious harm. If such is the case, the mentally retarded person shall be required to submit a three-day notice of intention to leave. The Superintendent may then seek to retain the person by petitioning the court. Stipulations at page 28, Admission packet page 3, 4.

(VII.) *RULES AND REGULATIONS GOVERNING INFORMED CONSENT AND THE CIVIL RIGHTS OF PATIENTS*

The Department of Mental Health Regulations governing civil rights of patients, include:

148.) Section 221.02 *Civil Rights* No person shall be deprived of the right to manage his affairs, to contract, to hold professional, occupational or vehicle operator's licenses, to make a will, to marry, to hold or convey property, or to vote in local, state, or federal elections solely by reason of his admission or commitment to a facility except where there has been an adjudication that such person is incompetent, or when a conser-

vator or guardian has been appointed for such person. In the event of conservatorship, a patient's civil rights may be limited only to the extent of the conservator's adjudicated responsibility. (Department of Mental Health Regulation, Section 221.02. See also Massachusetts General Laws, Chapter 123, Section 25.) (Stip. pp. 17, 18.)

149.) Section 221.03 *Right to treatment* Each patient admitted to a facility shall receive treatment suited to his needs which shall be administered skillfully, safely, and humanely with full respect for his dignity and personal integrity. Each patient shall receive such medical, vocational, social and rehabilitative services as his age, condition, and abilities require to bring about an early return to his community. (Department of Mental Health Regulation, Section 221.03.) (Stip. p. 18.)

150.) Section 220.06 *Informed Consent for electroconvulsive treatment*

(a) Informed written consent shall be obtained from each patient, guardian or nearest relative by the treating physician on consent forms provided by the Department. The person giving consent may withdraw such consent in writing at any time.

(b) For a patient on voluntary admission status under Part 211 or conditional voluntary admission status under Part 212 who is sixteen years of age or older, no person other than the patient may sign the consent form for ECT pursuant to Section 220.02.

(c) A parent or nearest relative may sign the consent form for a patient under sixteen years of age, or for a patient sixteen years of age of over who has been involuntarily committed to the facility under G.L. c. 123.

(d) A court-appointed guardian may sign the consent form for a legally incompetent patient. (Department of Mental Health Regulations, Section 220.06)

151.) Section 220.02 *Consent to treatment* Upon admission to a facility for care and treatment, a person shall receive treatment and rehabilitation in accordance with accepted therapeutic practice, including oral, subcutaneous and intramuscular medication when appropriate and when ordered by a physician. However, electroconvulsive treatment and lobotomy shall require separate consent by the patient pursuant to G.L. c. 123, s. 23.

(a) In the event of a patient's refusal of such electroconvulsive treatment or lobotomy, the facility shall obtain written consent from the patient's legal guardian or nearest living relative, provided that no guardian or relative may consent to such procedures for a legally competent patient on voluntary admission status of conditional voluntary admission status.

(b) In the event of a written refusal of electroconvulsive treatment by a patient over the age of sixteen on voluntary, conditional voluntary, or ten day emergency admission status, the superintendent or other head of the facility may order an evaluation of the legal competency of such patient. Following such an evaluation, the superintendent or other head of the facility may initiate guardianship proceedings under G.L. c. 201 before a court of competent jurisdiction. Until there has been an adjudication of competency by such court, no electroconvulsive treatment may be administered to the patient. (Department of Mental Health Regulation, section 220.02) (Stip. pp. 14, 15.)

152.) Under Regulation MH 16-7 of the Department of Mental Health Regulations which had full force and effect December 15, 1972, No. 7, states:

> "Each facility under the supervision and control of the Department or licensed by the Department shall post a copy of the rights articulated in this regulation in the admission room of the facility in each residential unit or any other appropriate places in the facility."

(D—*KANTAR* TR. 11-135, lines 15-24.)

153.) Pursuant to the Department of Mental Health Regulation MH 16-7, a civil rights poster was posted on the wards of the May and Austin Units. The same rights listed on the civil rights poster was placed on a civil rights form and was received in an Admission's packet by patients. (D—*KANTAR* TR. 110128,129,130; 11-36, lines 1-16. Stipulation Admission packet given to patient on page 3 "Legal Condition Under Which A Patient May Be Admitted to Boston State Hospital.")

154.) A poster on civil rights was placed on the wards for all patients to read. (Statement of Agreed Facts for Damages and Injunctive Relief, Medication #1.) (Stip. p. 3.)

155.) In relevant portions, this form states:

YOUR RIGHTS

You Have The Right To Be Treated With Dignity And Respect

You Have The Right To Privacy

TREATMENT RIGHTS:

You have the right to:

- be told in detail what is wrong with you, what alternative treatments are available, and to choose from these alternatives.
- be informed of the risks and possible side effects of treatment, *and to refuse treatment at any point.*

Restraints and Seclusion: You may be restrained only in case of emergency. Such restraints or seclusion must be justified in your record, and must be reviewed by the superintendent within 8 hours.

(Patient's Rights pamphlet (emphasis added) Plaintiffs Exhibit #3.)

DR-155.) The civil rights poster specifically notes that rights (such as the right to refuse treatment) can be withheld for good cause. Pl. Ex. #3.

156.) In addition, as part of the Admission packet patients receive patients are informed in relevant part that:

PROCEDURES FOLLOWING ADMISSION:

A course of treatment may include counselling, medications, electroconvulsive treatment, and treatment of any medical condition that the patient may be found to have.

No medical or surgical treatments including electroconvulsive treatment are given without the consent of the patient. (Stipulations at page 29, Admission packet.)

(VIII.) *CIRCUMSTANCES IN WHICH PATIENTS RECEIVED DRUGS INVOLUNTARILY PRIOR TO THE COURT'S TEMPORARY RESTRAINING ORDER*

(A.) *The May Unit*

157.)A female patient, for example, was forcibly, medicated in 1975 after refusing her 8 p.m. medications. Prior to receiving the medication by hypodermic she was calm and not out of control. (P—Keller TR. 28-94, lines 2-15.)

DR-157.) Defendants' witness Phil Keller conceded that he was not present when this female patient, E.G., refused her medication and so does not know what her behavior had been prior to his coming on the ward. Tr. 28 at 94 (Keller).

E.G. is an older, middle-aged, Spanish-speaking person who suffers from a diabetic condition, as well as having had several minor cardiovascular accidents. As such, she cannot speak intelligently in Spanish and does not understand English, having come from Puerto Rico fairly recently. She has a diagnosis of chronic schizophrenia in addition to her medical problems. Tr. 69 at 8 (Cox).

On several of E.G.'s admissions to the May Unit, including her admission in the fall of 1974, when Phil Keller was employed there, she thrashed about and was physically assaultive to other patients and staff members. Because she could not be understood and because she was not making sense, staff was unable to learn from her what was causing her difficulty. On certain occasions, she was medicated forcibly to get her under control. Tr. 69 at 8, 9 (Cox).

E.G. has physically attacked patients. When she has done

so, she was not aware of what she was doing. She thrashed about and attacked anyone who happened to be near her. Tr. 69 at 9 (Cox).

158.) The patient Ronald B had his bed in the day hall and was told he had to take medication. He said he wasn't going to. He wasn't angry or intense, he just stated he wasn't going to take his medication. Mrs. Wilson, the supervisor on the shift told him if he persisted in refusing she would give him an intramuscular injection. He continued to refuse. A number of male staff came and told him to roll over on his bed in the day hall. He turned over and he received his medication by injection, with other patients present in the day hall. (P—Keefe TR. 23-36.)

DR-158.) When he was a patient at the May Unit in 1974, Ronald was diagnosed as manic-depressive, and he was in a hypermanic phase. He was extremely agitated, was threatening to harm himself, and was very difficult to control. Tr. 69 at 9, 10 (Cox).

In January, 1975, during Ronald's second admission to the May Unit, and while Steve Keefe was still employed there, Ronald was threatening to kill five patients on the ward, and in fact, had named them shortly after his admission; at that time he was given intramuscular medication and put into seclusion. Tr. 69 at 10 (Cox).

Ronald was a young man in his early twenties, whom Mrs. Wilson had known since he was a child. Ronald was in the day hall because he needed to be closely observed. Tr. 50 at 36, 37 (Siegel). When Ronald was in the hospital and under special observation, his condition constituted a psychiatric emergency and required medication. Tr. 50 at 37 (Siegel). Ronald was dangerous when not taking his medication. Tr. 50 at 37, 38 (Siegel).

159.) The patient Tom W, a young black male around 6 feet tall, was very incoherent. He was placed in seclusion to avoid him escaping. He received medication by injection. (P—Keefe TR. 23-36, lines 23-25; 23-37, lines 1-12.)

DR-159.) Absent further information regarding the patient Tom W., this testimony standing alone does not provide sufficient information to be able to determine whether Tom W.'s condition was or was not an emergency situation. There was no testimony of the alleged dates or people involved in this incident.

160.) The male patient, D.S., in 1975 was put in seclusion for an alleged act of masturbation in the day hall. Medication was also awarded and he refused to take it. So two men came in, myself being one of them, rolled him over, pulled down his strong pants, and the nurse gave him an injection. He passively resisted the medication. He was not engaging in any kind of hostile or dangerous behavior at that time. (P—Keller TR. 28-92; 28-93.)

161.) The patient, D.S., in 1975 was forcibly medicated during the 8 p.m. medications, after he refused his medication. He was lying in a bed in the day hall for observation. He passively resisted medication. He was not engaged in any kind of hostile or dangerous behavior at that time. (P—Keller TR. 28-92; 28-93.)

DR-160-161.) Phil Keller did not testify that D.S. passively resisted medication when he was forcibly medicated after refusing his 8 p.m. medications on one occasion in 1975. Tr. 28 at 92, 93 (Keller).

D.S. was a May Unit patient who had been convicted of armed robbery and sentenced to M.C.I. Walpole.

D.S. is a very large man, in his mid-thirties. While at Walpole, he became flagrantly psychotic and openly masturbated, rubbed his stomach, and talked about devils being inside of him.

D.S. was so uncommunicative and difficult to talk with at these times that he would move forward in odd ways, again rubbing his stomach, talking about devils being inside him. As he became more and more cut off from people in these psychotic states, he became violent. In fact, D.S.'s family had

sent him to the May Unit on a number of occasions because of his violence at home, including completely destroying his room, ripping the plaster so that all that remained was the external parts of the building. Many of the patients were frightened of him. Tr. 49 at 68; Tr. 50 at 17-19 (Siegel).

D.S. was transferred from Walpole to Bridgewater State Hospital. In Bridgewater and the May Unit, D.S. also openly masturbated. He masturbated at the May Unit during times when he was most withdrawn, cut off from the external world and most lost in his own fantasy, rubbing his stomach, making odd gestures with his forehead. At those times he was most dangerous, likely to lose control, and constituted a psychiatric emergency. He had a history of becoming violent when withdrawn. Tr. 50 at 17-19 (Siegel).

When D.S. masturbated, he talked of violent impulses connected with his sexual arousal. Tr. 50 at 21 (Siegel).

D.S. was not forcibly medicated every time he masturbated. Tr. 50 at 20 (Siegel).

D.S. was not forcibly medicated because he masturbated, but, rather, because he was withdrawn, uninvolved with people around him, and unable to communicate with staff. Tr. 50 at 19 (Siegel).

162.) A patient, E.A., was forcibly medicated after she refused her 8 p.m. medication. Prior to being told she was going to be forcibly medicated, she was calm. After she was informed she was to receive the medication by force she started crying and resisting. She was forcibly turned over onto her stomach and medicated by a hypodermic. (P—Keller TR. 28-93, lines 15-25; 28-94, lines 1-3.)

DR-162.) E.A. was forcibly medicated for medical reasons, i.e., in order to enable the staff to treat a medical condition. E.A. had very edemic legs which at times required treatment and on one occasion resulted in her being hospitalized at the D-Building, the medical unit for Boston State Hospital. At times E.A. paced and staff had to slow her down. She would

be given medication on those occasions to somewhat sedate her so that staff were able to have her sit and keep her feet raised. Tr. 68 at 132 (Ford.)

163.) The patient, Ann S., a small woman in her middle to late 50's or early 60's, diagnosed as a manic depressive, was told by the staff if she didn't take her regular medication orally she would be put in seclusion. She then agreed to take her medication. (P—Keefe Tr. 23-35, lines 1-15; 23-36, lines 3-6. D—*SEIL* TR. 58-21, lines 17-25.)

DR-163.) If Ann S. was not taking medication, she would require seclusion for her own protection. Ann S. has been frequently admitted to the May Unit. She responded very well to lithium carbonate. When she was not on this medication, she was extremely hyperactive. She did not sleep. She did not eat properly. Her weight diminished considerably. She complained a great deal about any number of things usually about why she could not go home. From time to time she pestered and complained to patients who tended to be somewhat explosive, particularly when they were trying to be quiet. This aroused a great deal of anger, and Ann S. had occasionally been assaulted by other patients because of this behavior. Tr. 58 at 26, 27 (Seil).

Dr. Seil did not testify that Ann S. had been threatened with seclusion if she refused to take her medication.

164.) The patient, Terry W., was told that if she persisted in refusing her regular medication she would be put in seclusion without any clothes on and that scared her so she took the medication. She was informed of that by Mrs. Wilson the charge nurse and supervisor of the 3-11 shift on May 3 ward. P—Keefe TR. 23-35, lines 15-23; 23-36, lines 3-6.)

DR-164.) Absent further information regarding the patient Terry W., this testimony standing alone does not provide sufficient information to be able to determine whether Terry W.'s condition did or did not create an emergency situation.

165.) On 10/3/73, M.B. was to be given medication I.M., if

refuses P.O. The staff insisted that she remain out of bed. She did take her 1 p.m. medication P.O. (Plaintiffs Exhibit #33 at page 5, dated 10/3/73 day shift.)

DR-165.) Absent further information regarding the patient M.B., this entry in the nurses' report book standing alone does not provide sufficient information to be able to determine whether M.B.'s condition did or did not create an emergency situation. See Defendants' Proposed Findings J-45-J-50.

166.) P.F. to get thorazine concentrate or I.M. if refused may give stelazine by tablets and has P.R.N. order if needed. (Plaintiffs Exhibit #33 at page 6, 10/17,18/73 day shift.)

DR-166.) Absent further information regarding the patient P.F., this entry in the nurses' report book standing alone does not provide sufficient information to be able to determine whether P.F.'s condition did or did not create an emergency situation. See Defendants' Proposed Findings J-45-J-50.

167.) M.G. was secluded from 7-8 and 9-11 on 10/25/73 for control. She was described by staff as denudative, bizarre and uncooperative. She was then given thorazine 25 milligrams I.M. at 7:30 p.m. (Plaintiffs Exhibit #33 at page 20.)

168.) M.G. refused P.O. medication on 10/27/73 day shift and was given 50 milligrams I.M. of thorazine at 8 a.m. (Plaintiffs Exhibit #33 at page 20.)

169.) M.G. refused her P.O. medication on the evening shift on 10/30/73. I.M. was given, 50 milligrams of thorazine. She was not eating anything and intake of fluids was poor. (Plaintiffs Exhibit #33 at page 20.)

170.) M.G. was secluded from 12:30 p.m. to 3:00 p.m. on 10/30/73; verbalizing "open the door", "I want to go home," pacing, taking her robe off. Secluded at 12:30 for taking clothes off continually. Still very bizarre, confined at 8 a.m. At 12 noon Haldol 5 milligrams I.M. (Plaintiffs Exhibit #33 at page 20.)

171.) M.G. on 10/31/73 in seclusion throughout the evening

shift; ate very little, medication given I.M. (Plaintiffs Exhibit #33 at page 21.)

DR-167-171.) On October 26, 1973, M.G. was confused, pacing, agitated, restive, resistive, and showered with difficulty. On the 3 to 11 shift that day, she was unresponsive. Pl. Ex. 29, p. 20.

On October 30, 1973, during the 7 to 3 shift, M.G. was *not* "confined" at 8 a.m. and 12 noon, but was "confused" at 8 a.m. and 12 noon. PL. Ex. 29, p. 20.

Absent further information regarding the patient M.G., these entries in the nurses' report book standing alone do not provide sufficient information to be able to determine whether M.G.'s condition was or was not an emergency situation. See Defendants' Proposed Findings, J-45-J-50.

172.) Ruby Rogers refused a.m. medication on the day shift on 11/12/73, given Haldol I.M., in control. (Plaintiffs Exhibit #33 at page 21.)

DR-172.) By late October and early to mid-November, 1973, Rubie Rogers' condition was not showing much improvement. She continued to be hostile, aggressive, difficult to approach, delusional. She felt that rats were in her feet and snakes were biting her legs. Her associations were loose, and she experienced great fluctuations in mood. She was refusing to participate in group activities and could not tolerate any discussions regarding the reasons she was in the hospital. Pl. Ex. 9, Doc. Nos. 500009A, 500006, 500010, 500009B, 500009C. On November 13, 1973, she refused Haldol and was not given it. Pl. Ex. 29, p. 21.

173.) A.F. refused P.O. medication in a.m. on 11/29, 30/73. Given 10 milligrams Haldol I.M. without difficulty. Took p.m. medication P.O., seemingly very depressed. (Plaintiffs Exhibit #33 at page 22.)

DR-173.) During November and December, 1973, A.F. was very depressed and suicidal. On November 1, 1973, she escaped from the May Unit, and tried to jump into a truck on Morton Street. When returned to the Unit, she stated she

wanted to die; at that time she was given PRN medication with good results. On November 29, 1973, she again attempted to escape from the Unit, but was brought back by police. On December 9, 1973, she was depressed and asking an attendant to kill her. On December 10, 1973, she stated that she wanted to kill herself. Def. Ex. FF.

174.) On 10/30/73, 7-3 shift E.A was refusing prolixin shot, threatening to hurt people if we forced him. However, when men were called he took it without a fight. On a day pass until one p.m. job hunting. If hasn't returned by 1:30, put him on escape. (Plaintiffs Exhibit #33 at page 7.)

DR-174.) E.A. was a very violent man who needed antipsychotic medication. Tr. 50 at 39, 40 (Siegel).

E.A had been an inmate at Bridgewater State Hospital a number of times. He was very excitable, and when he was not taking medication, he became very paranoid and delusional. When living at home and having stopped his medication, his family members locked their bedroom doors out of fear that he would harm them. When not on medication, E.A. had thrown the family dog off the second floor porch a number of times. Tr. 50 at 39 (Siegel).

As of October 30, 1973, E.A.'s medication orders included an injection of Prolixin Enanthate every two weeks. Def. Ex. FF.

On July 3, 1973, E.A. made a serious suicide attempt, requiring hospitalization at Boston City and Boston State Hospitals. On August 13, 1973, he was found comatose in the woods by Boston City Police after he had taken an overdose of pills. He was treated at Boston City Hospital and walked off the ward after an argument with his mother. On September 25, 1973, he was taken to Boston City Hospital by police after raising a kitchen knife to his mother. While at the Boston City Hospital emergency ward, he was out of control, threatening patients and staff with a hammer. He was then admitted to Boston State Hospital on September 25, 1973. He was placed

on suicide precautions, was restricted to the ward in pajamas, and was to be watched for self-destructive behavior. He was transferred to the Lemuel Shattuck Hospital for treatment of ulcerations.

While at the Shattuck, he hit a mongoloid patient and was transferred to the Boston State Hospital Medical Building on October 4, 1973. While there, without provocation, he attacked a patient who was just being admitted after surgery and was then transferred to the May Unit, where he was assaultive, requiring seclusion. He attacked a night attendant by attempting strangulation. Def. Ex. FF.

175.) On 11/8/73 7-3 shift, A.H. alternately cruel and hostile. Refused concentrate at 1:00 p.m. given I.M. medication. (Plaintiffs Exhibit #33 at page 7.)

176.) On 11/9/73 day shift, A.H. refused concentrate medication all day. Has been given I.M. Most of her day has been spent in bed, extremely hostile if you try and talk to her. (Plaintiffs' Exhibit #33 at page 7.)

Dr-175-176.) A.H. was admitted to the May Unit on November 7, 1973, after having a dispute with a landlord, becoming abusive to a housekeeper, and showing a gun to other tenants in her apartment building. Her landlord called the police, who brought her to the hospital. Def. Ex. FF.

When A.H. was admitted to the May Unit on November 7, 1973, she was hostile, suspicious, and paranoid and was diagnosed as schizophrenic, paranoid type. Def. Ex. FF.

177.) R.C. refusing medication on morning of 11/13/73. Spit concentrate out, forced to take I.M. Secluded for one hour because he hit out on attendants after being medicated. (Plaintiffs Exhibit #33 at page 7.)

DR-177.) Absent further information regarding the patient R.C., this entry in the nurses' report book standing alone does not provide sufficient information to be able to determine whether R.C.'s condition did or did not create an emergency situation. See Defendants' Proposed Findings J-45-50.

178.) On 12/3,4/73 night shift, A.A., was upset because she was given a couple of needles up at the building. She states she was promised she wouldn't be given a needle. She believes they are using her as a guinea pig. (Plaintiffs Exhibit #33 at page 9.)

Dr-178.) On this occasion A.A. was "given a couple of needles up at the D building." Pl. Ex. 29, p. 9. The D Building was the medical center where Boston State Hospital (patients) received treatment for medical conditions. Tr. 68 at 132 (Ford). Standing alone, there is no evidence of what type of medication, if any, A.A. received at the D Building, nor is there any evidence tieing this receipt of medication to the May Unit.

179.) On the evening shift on 3/20/74, G.O. was secluded for forcibly resisting when told he had to take I.M. medication for refusing concentrate. On 3/18/74 the staff respected his refusal because he said he had an upset stomach and headache and did not want it. (Plaintiffs Exhibit #33 at page 13.)

179.) On March 18, 1974, G.O. refused his medication and was not given it against his will. Pl. Ex. 29, p. 13.

G.O.'s refusal of medication in March, 1974, was the result of his delusion that the doctors were experimenting with him, varying his dosage of medication day to day, despite the staff's attempts to assure him that this was not the case. Def. Ex. FF.

180.) B.R. at 11 a.m. on 5/9/74 was told staff she had spit out her 9 a.m. pill. Told she would have to have either concentrate or I.M. from now on. Please adhere to this until further notice. (Plaintiffs Exhibit #33 at page 16.)

181.) B.R. in seclusion at 12 noon on 5/13/74 for not taking medication, refused very firmly. Secluded on May 4, took medication concentrate at 1:45 p.m. (Plaintiffs Exhibit #33 at page 16.)

182.) A.R. was in seclusion for a short while on 5/15/74. She would not take medication, threw it out. Was given 50 milligrams of I.M. thorazine. She was still acting up. When

she gets out she is going to run. (Plaintiffs Exhibit #33 at page 17.)

DR-180-182.) "A.R." is the patient "B.R.". Def. Ex. FF. when B.R. was admitted by her guardian to the May Unit on May 3, 1974, she was fifteen years old and had a long history of violent acting out, of not being able to control her impulses, and of involvement with the courts and institutionalizations. She had recently threatened her sister with a knife and stated she would try to kill her. She once attempted to take an axe to a counsellor at Goodwill Camp; while at the Lancaster facility of the Department of Youth Services, she attempted to burn attendants with cigarettes, pulled the radiator out of the wall, and was felt uncontrollable. At the May Unit, she was placed on strict violence and homicide precautions. She was belligerent and hit out at many staff members. She escaped on June 11, 1974, and was thereafter discharged. Def. Ex. FF.

After B.R. was committed to Metropolitan State Hospital for observation, it was recommended that B.R. was in need of a structured setting with facilities for dealing with her disruptive behavior and her need to test limits. The goals of her treatment plan at the May Unit were to provide limit setting to help the patient to internalize controls. Def. Ex. FF.

At the May Unit, B.R. lost control and threw an ashcan at a staff member. Pl. Ex. 29, p. 15.

B.R. was secluded on May 9, 1974, following a physical struggle with May Unit staff. Def. Ex. FF.

B.R. had been screaming, stealing, and acting out prior to her seclusion on May 13, 1974. She was not secluded because she refused medication. Def. Ex. FF.

183.) O.G. ran out of the building on the evening shift on 5/17/74 when the staff tried to give him medication. He was brought back and given a shot and secluded. (Plaintiffs Exhibit #33 at page 17.)

DR-183.) After he was released from seclusion on May 17, 1974, O.G. was very quiet. Pl. Ex. 29, p. 17.

O.G. was brought to the May Unit by police and involuntarily admitted on May 13, 1974, pursuant to M.G.L. c. 123, § 12, having experienced an acute schizophrenic break. Def. Ex. FF.

When admitted to the May Unit on May 13, 1974, he became extremely agitated and frightened, had poor judgment and no insight, expressed paranoid delusions, appeared to have auditory hallucinations, held his head and banged it against the wall. He had not been eating and sleeping and was to be watched for dehydration, Def. Ex. FF.

O.G.'s treatment plan included medication to calm him so he would be less frightened, encouragement to eat, reassurance, and observation of whether he slept. Def. Ex. FF.

When admitted to the May Unit on May 13, 1974, O.G. expressed fear that he would be sexually assaulted by males. On May 15, 1974, he feared that he was being held at the May Unit for experimental purposes, to cause him to become pregnant and have babies; that he was being hypnotized; and that the shape of his body was changing, his hips becoming round rather than "square" as men's are supposed to be. Def. Ex. FF.

O.G. is a young man, who is generally in a manic state when he is brought to the hospital by authorities. He experiences during those periods a great deal of sexual identity confusion and that he firmly believes he is a female and dresses as such on the streets. It is during these times that he is disorganized and impulsive, that he wishes to leave the hospital in such impulsive manner. And it was the opinion of the staff that when he's under such disorganization, it is dangerous for him to be out in the community. Tr. 58 at 28, 29 (Seil).

184.) On the day shift on 5/19/74, B.R. was not given her clothes because two verbal threats to leave made yesterday. Acted disappointed and angry at first but remained in surprisingly good control. However when noon medications were given Bunny spit her concentrate on the floor, given I.M.

Haldol as ordered. Took this cooperatively so was not secluded. (Plaintiffs Exhibit #33 at page 17.)

DR-184.) As of May 19, 1974, B.R. was still physically attacking May Unit staff members and had threatened another patient on the ward. Def. Ex. FF.

185.) The plaintiff Ruby Rogers was involuntarily and forcibly medicated in non-emergency situations. (See detailed Proposed Findings for Ruby Rogers under her assault and battery and malpractice claims.)

186.) The plaintiff Harold Warner was involuntarily and forcibly medicated in non-emergency situations. (See detailed Proposed Findings for Harold Warner under his assault and battery and malpractice claims.)

187.) The plaintiff Willie Wadsworth was involuntarily and forcibly medicated in non-emergency situations. (See detailed Proposed Findings for Willie Wadsworth under his assault and battery and malpractice claims.)

188.) The plaintiff Able Bolden was involuntarily and forcibly medicated in non-emergency situations. (See detailed Proposed Findings for Able Bolden under his assault and battery and malpractice claims.)

(B.) *The Austin Unit*

189.) M.N. was lying in her bed at the time medication was given in the evening. Neil Cariello, a staff member, came around and informed M.N. that the medication nurse was up and that she should get out of the bed. M.N. obviously was falling asleep. Mr. Cariello tried to wake M.N. up but she was not responsive. Mr. Cariello went out to help with the other patients medication. He came back several times and informed M.N. that the medication nurse was up. The medication nurse came into M.N.'s room. The staff informed M.N. that unless she took her medication orally, she would be given an injection. She refused and she was given an injection. (P—Cariello TR. 22-23, lines 1-18.)

DR-189.) M.N. had periods of acute depression when she was very morose, ghost-like, ethereal, lacked energy, and walked around the ward saying she was not living, she was dead. Tr. 22 at 41 (Cariello).

190.) In September or October 1973, at approximately 10 p.m., Betsy Franceen received a call from her nursing supervisor that there was a patient in the admitting room and some information needed to be taken on that person. The supervisor asked Ms. Franceen to come down to the room and start asking some questions of the patient. Ms. Franceen walked into the room and sat down. The patient, a woman who was around 20-years old, was very quiet. She was sitting across from Ms. Franceen. Ms. Franceen asked her questions, such as where she lived, and some general informational questions which she was not at all interested in answering. Ms. Franceen tried a few more questions and then she stopped asking her questions because she realized that that is not at all where the patient's focus was at that time; that the patient was quite upset, but calm. At this point the doctor came into the admitting room and began asking her the questions himself. She directed some specific questions to the doctor about the hospital, about medication, specifically, and being locked up. She had some real fears about being medicated against her will and some fears against being locked up against her will. And the doctor was, at the beginning, not answering her questions at all, which was upsetting her more and more. She jumped up at one point after this had been going on for a period of time, maybe 20 minutes, and knocked over a phone. After this action, she pulled herself back a little, sat back down, said she was sorry, and the doctor began to answer some of her questions. He reassured her that: "No, she would not be medicated," and, that: "No, she would not be locked up." At this point, Ms. Franceen was getting very upset because she knew that whether she was locked in seclusion or not, she would be locked up because A-6 was a locked ward, and she felt like the

doctor was giving the patient false information. At that point the doctor left the room. He didn't tell Ms. Franceen where he was going, but in five to six minutes two attendants came into the room and asked the patient to come with them. She walked out of the room and they headed down the hall. This was on the first floor towards the door leading up to the top floor on A-5. At the point where she saw that they were taking her upstairs, she started to resist. The two attendants took her on either side of her arms and forcibly escorted her upstairs onto the ward. She was becoming more and more frightened and asking them not to do this, that she didn't want to go in there and please don't bring her into the hospital. They continued down the hall, the nursing supervisor from the night shift joined them at the nursing station and two more attendants came out of the nursing station. The four of them continued escorting her down the hall into the back day hall and into the seclusion room. She really became agitated at this point and started crying and pleading with them not to bring her in there. The attendants were all male attendants. They pushed her down on the mat that was laying in the seclusion room, pulled down her pants. The nursing supervisor, who was a woman, took the needle and attempted to give her a shot. The needle broke. They fumbled around for a little bit longer, found another needle and succeeded in giving her the medication. DR-190.) T.S. was an involuntary patient who was sent to the Austin Unit on a 10-day commitment paper from the Mass. General Hospital. Tr. 64 at 47 (Gill).

Prior to her admission to the Austin Unit, T.S. had been taken to the Mass. General Hospital because she had been threatening to kill her employer and was also threatening to jump off a bridge. Tr. 64 at 47 (Gill).

After being transferred from the Massachusetts General Hospital, T.S overturned a desk and was disruptive in the Austin Unit evaluation area. Tr. 64 at 47 (Gill).

T.S.'s behavior was very wild. Her agitation, destruc-

tiveness, and assaultiveness did not end after she was admitted to the Austin Unit, but continued for a few days. Tr. 64 at 47 (Gill).

The physician who admitted T.S. to the Austin Unit is not Dr. Gill or Dr. Kantar. Tr. 20 at 90 (Franseen).

191.) The plaintiff Elizabeth Bybel was forcibly and involuntarily medicated in non-emergency situations. (See detailed Proposed Findings for the plaintiff Elizabeth in her medication assault and battery and malpractice claims.)

192.) The plaintiff James Colleran was forcibly and involuntarily medicated in non-emergency situations. (See detailed Proposed Findings for the plaintiff James Colleran in his medication assault and battery malpractice claims.)

193.) The plaintiff Donna Hunt was forcibly and involuntarily medicated in non-emergency situations. (See detailed Proposed Findings for the plaintiff Donna Hunt in her medication assault and battery and malpractice claims.)

(C.) *The May and Austin Units*

194.) Doctors ordered or authorized the forcible medication of:

a.) Conditional voluntary patients;
b.) Court committed patients;
c.) Patients on a 10-day emergency commitment;
d.) Patients being held by the hospital pending a court commitment hearing;

in circumstances in which they refused their regularly prescribed oral medication in non-emergency situations. (D—*KAHN, KANTAR, MALAMUD, MAZMANIAN, SEIL, SIEGEL, SZLYK, TURNQUEST, GILL.* Second set of Admissions, No. 14.) (Plaintiffs' Exhibit 34.)

DR-194-224B.) See generally Defendants' Proposed Findings of Fact, J-86-107, 126-135.

Dr-194.) See Defendants' Proposed Finding of Fact, J-89, 90.

195.) It was a general practice to inform patients that if they didn't take their medication they would receive it through a hypodermic needle. (P—*ROGERS*, TR. 28-22, 23, 24, 25, 26. P—Keller, TR. 28-90, line 25; 28-91. P—Franceen TR. 20-45, 46, 47, 48, 49, 50; 20-53, lines 22-25; 20-54, line 1. P—Cariello TR. 22-7, 8, 10, 11, 12; 22-14, lines 12-25; 22-15, lines 1-3.)

196.) Some patients were threatened with seclusion or were secluded if they persisted in refusing their regular medication. (P—Keefe TR. 23-34, lines 17-25; 23-35; 23-36. P—*ROGERS* TR. 28-22, 24, 25, 26. P—Keller TR. 28-81.)

197.) Doctors ordered or authorized the administration of forcibly or against a patient's will as part of a patient's planned therapeutic program, even though the patient has not given his/her informed consent.

a.) Prolixin. (D—*OSBORNE* First Set of Admissions #48.)

b.) Prolixin Decanoate. (D—*MAZMANIAN, TURNQUEST, GILL, OSBORNE* First Set of Admissions #48.)

c.) Prolixin Enanthate. (D—*TURNQUEST* First Set of Admissions #48.)

Dr-197-198.) Prolixin decanoate was never used against a patient's will at the Austin Unit. Tr. 48 at 17-18 (Kantar).

198.) Prolixin decanoate is a long acting antipsychotic medication. (D—*KANTAR* TR. 12-109; 12-110.)

199.) It was a doctor's general policy and practice to authorize or order the medication of patients, regardless of whether or not they had their consent, when they felt it was in their best medical interest. (D—*GOLDBARG* Second Set of Admissions #7.) (plaintiffs' Exhibit 34.)

DR-199.) As Drs. Gill and Seil noted, medication was ordered in the best medical interests of patients. The ordering of medication did not mean that a patient could not refuse it. Gill and Seil, Second Set of Admissions, #7.

200.) A doctor's decision to order or authorize the medication forcibly or against a patient's will for refusing to take his/her regular and oral medication was not affected by whether the patient was:

a.) A conditional voluntary patient;
b.) Court committed;
c.) On a 10-day emergency commitment;
d.) Held by the hospital pending a court commitment hearing.

(D—*KAHN, KANTAR, MALAMUD, MAZMANIAN, POMERANTZ, SCHILDKROUT, SEIL, SEIGEL, SZLYK, GILL* Second Set of Admissions #15. D—*KANTAR* TR. 13-7, lines 24-25; 13-8, lines 1-4.)

201.) Prior to April 30, 1975, the doctors at times did not inform their patients who were medicated as part of a planned therapeutic program of the effect, side effects, and risks of the proposed medication. (D—*GOLDBARG, OSBORNE* First Set of Admissions #47.) (Plaintiffs' Exhibit 34.)

202.) Doctors have ordered or authorized the involuntary medication of some patients who they believed were not able to make a rational decision about their medication but they believed were rationally able to vote, contract, sign a voluntary, manage their own affairs, hold a professional or occupational license, to make a will, to consent to or to refuse other aspects of a treatment program not including medication. (Statement of Agreed Facts for Injunctive Relief only, #1.) (Stip. p. 351.)

203.) Doctors have denied some patients, who were able to make rational decisions as to some matters (those matters included: a) to contract; b) to vote; c) to manage their affairs; d) to sign into the hospital as a voluntary; e) to hold professional or occupational licenses; f) to consent to or refuse other aspects of their treatment plan not including medication), requests or demands to be removed from their medication or have the type of dosage of medication changed in cir-

cumstances in which they considered the medication was benefitting the patient psychologically even though the patient complained of adverse side effects. (Statement of Agreed Facts for Injunctive Relief only, ¶2.) (Stip. p. 352.)

204.) It was doctors' general policy and practice to order or authorize the medication of patients involuntarily held pending a commitment hearing regardless of whether or not they had given their consent, when they felt they had non-emergency psychiatric needs about which they could not make rational treatment decisions. (D—*GOLDBARG, TURNQUEST* Second Set of Admissions ¶12.) (Plaintiffs' Exhibit 34.)

205.) It was doctors' policy and practice to order or authorize the medication of involuntary patients regardless of whether or not they had given their consent, when they felt they had non-emergency psychiatric needs about which they could not make rational treatment decisions. (D—*GOLDBARG, TURNQUEST* Second Set of Admissions ¶10.) (Plaintiffs' Exhibit 34.)

DR-205-208.) While the propositions were admitted by either Drs. Goldbarg, Turnquest or Cacciola, as Dr. Seil noted, the ordering or authorizing of medication did not mean that a patient could not refuse it. Seil, Second Set of Admissions, ¶10.

206.) It was doctors' general policy and practice to order or authorize the medication of involuntary patients, regardless of whether or not they had given their consent, when they felt they had non-emergency medical needs about which they could not make rational treatment decisions. (D—*GOLDBARG, TURNQUEST* Second Set of Admissions ¶11.) (Plaintiffs' Exhibit 34.)

207.) It was doctors' general policy and practice to order or authorize the medication of voluntary patients, regardless of whether or not they had given their consent, when they felt they had non-emergency medical needs about which they

could not make rational treatment decisions. (D—GOLDBARG Second set of Admissions #9.) (Plaintiffs' Exhibit 34.)

208.) It was doctors' general policy and practice to order or authorize the medication of patients involuntarily held pending a commitment hearing, regardless of whether or not they had given their consent, when they felt they had non-emergency medical needs about which they could not make rational treatment decisions. (D—*TURNQUEST* Second Set of Admissions #13.) (Plaintiffs' Exhibit 34.)

209.) The doctors at the May Unit ordered or authorized the involuntary or forcible medication of patients if the doctors believed the medication would benefit the patient even if it were a non-emergency situation, where there was no threat of harm to self or others. (D—*MAZMANIAN* TR. 49-30, lines 10-25; 49-31; 49-32).

DR-209.) Dr. Mazmanian did not testify that the doctors at the May Unit ordered or authorized the involuntary or forcible medication of patients in a non-emergency. In fact, Dr. Mazmanian said that he didn't believe that he had a general practice in terms of a general policy. Tr. 49 at 32, lines 10-11 (Mazmanian). In fact, no doctor testified that they involuntarily or forcibly medicated patients in a non-emergency. The only evidence of involuntary medication in non-emergencies comes from the admissions and interrogatories, when defendants were defining emergency in the strict sense to mean a situation where there was a serious threat of personal injury to the patient or others. See Defendants' Proposed Findings, J-86-90.

210.) It was the general policy and practice of the doctors to forcibly or involuntarily medicate patients with antipsychotics in non-emergency situations, even when the patients were calm and the patients specifically refused their medication. (P—Franceen TR. 20-45, 46, 47, 48, 49, 50, 51, 52, 53; 20-54, line 1. P—Cariello TR. 22-7, 8, 10, 11, 12; 22-14, lines 12-25; 22-15, lines 1-3. D—Green TR. 61-70, lines 12-25; 61-71, lines 1-2, 5-6, 6-14, 21-23; 61-72, lines 7-10. D—*KANTAR* TR.

13-35, lines 9-12, 19-22; 13-36, lines 14-17; 11-154, lines 22-25; 11-155, lines 1-7; 11-157, 158; 11-159; 11-128, lines 15-21. D—*GILL* TR. 64-48, lines 10-17; 64-55; 66-75; 76, 77, lines 4-9. P—Keefe TR. 23-34, lines 17-25; 23-35; 23-36. P—Keller TR. 28-90, line 25; 28-91; 28-92; 28-93; 28-94. P—Golder TR. 7-51. See Proposed Finding #194-209.)

DR-210.) Neither Ms. Green nor Dr. Kantar nor Dr. Gill testified on the pages cited that it was the general policy and practice of the doctors to forcibly or involuntarily medicate patients with antipsychotics in non-emergency situations. (D—Green, Tr. 61 at 70, lines 12-25; Tr. 61 at 71, lines 1-2, 5-6, 6-14, 21-23; Tr, 61 at 72, lines 7-10; Kantar, Tr. 13 at 35, lines 9-12, 19-22; Tr. 13 at 36, lines 14-17; Tr. 11 at 154, lines 22-25; Tr. 11 at 155, lines 1-7; Tr. 11 at 157, 158; Tr. 11 at 159, Tr. 11 at 128, lines 15-21; Gill Tr. 64 at 48, lines 10-17; Tr. 64 at 55, Tr. 66 at 75, 76, 77, lines 4-9).

211.) It was the general policy and practice to medicate patients forcibly or involuntarily with antipsychotics when there was not a serious threat of or as a result of extreme violence, personal injury or attempted suicide. (D—*SEIL* TR. 58-61, lines 12-19. See Proposed Findings #194-210.)

212.) Prior to the issuance of the temporary restraining order, medication was used involuntarily in non-emergencies as part of a planned psychotherapeutic program. (D—*SEIL* TR. 58-72, lines 1-7; 58-72, lines 17-22. D—*GILL* TR. 11-148; 11-149. See also Proposed Findings #194-211.)

DR-212.) Neither Dr. Seil nor Dr. Gill testified on the pages cited that prior to the issuance of the temporary restraining order, medication was used involuntarily in non-emergencies as part of a planned psychotherapeutic program.

213.) As a policy and practice, the doctors would make a substitute decision, and order that the patient be involuntarily or forcibly medicated when the doctor believed that the patient was in discomfort or anguish that was unnecessary or unacceptable, and the patient did not feel the medication was

in his/her best interest. (D—*KANTAR* TR. 11-160, lines 4-12. D—*GILL* TR. 64-53; 64-54; D—*MAZMANIAN* TR. 49-30, lines 10-25; 49-31; 49-32.)

DR-213.) Neither Drs. Kantar, Gill or Mazmanian testified that they would make a substitute judgment as policy and practice on the pages cited in this finding. Rather, they indicated that they might make a substitute judgment if the situation warranted. See also Defendants' Proposed Finding. J-93, 96.

213a.) If a patient was psychotic and sitting in a corner depressed, not bothering anyone, not dangerous to himself, but the doctors believed the consequence of the failure to take medication might be that the patient may remain in the hospital indefinitely, the doctors would forcibly or involuntarily medicate the patient, if the patient refused the medication. (D—*KANTAR* TR. 11-167, 168, 169, 170. D—Olin TR. 51-32, 33, 34. D—Counsel of Defendants TR. 51-34, lines 9-13.)

DR-213a.) Neither Drs. Kantar, Olin, or defense counsel stated that a psychotic patient as described in this finding would be forcibly medicated, but that such patient might be medicated if the situation warranted. See Defendants' Proposed Finding, J-94.

213b.) If a patient was rational but in a highly disturbed state and was in a great deal of pain the doctors would forcibly or involuntarily medicate the patient if the patient refused his medication. (D—*GILL* TR. 64-53, 54.)

Dr-213b.) Dr. Gill did not testify that a patient in the condition described in this finding would be involuntarily or forcibly medicated. Rather, Dr. Gill testified that the symptoms described in this finding were one factor that would be taken into account when deciding whether to involuntarily or forcibly medicate a patient. Tr. 64 at 53-54 (Gill).

213c.) The policy and practice of the doctors in the Austin Unit was that they would forcibly or involuntarily medicate a

patient, even if the patient specifically refused the medication, if the doctors believed the patient's mental condition was any one of the following:

a.) in a state of psychotic turmoil; or,
b.) in a state of acute psychosis; or,
c.) in a state of delusional thinking; or,
d.) in a state where the patient is florid with anxiety; or
e.) in a state where the patient can't function; or
f.) in a state where the patient can't make a decision; or
g.) in a state in which the patient is in a great deal of pain or distress.

(D—*GILL* TR. 65-112.)

DR-213c.) Dr. Gill testified that as a doctor he should be able to forcibly and involuntarily medicate patients with the symptoms described in this finding. He did not testify that it was policy and practice that patients with these symptoms would be forcibly and involuntarily medicated.

213d.) The doctors would order or authorize the forcible or involuntary administration of antipsychotic medication in circumstances in which the doctors believed such medication would temporarily relieve the delusions, even though the patient was refusing the medication and was eating and was being cared for in the hospital, was thriving in the hospital, was not bleeding, nor bothering anybody nor punching anyone. (D—*KANTAR* TR. 11-167, 168, 169, 170.)

DR-213d.) Dr. Kantar did not testify that the doctors would authorize the forcible or involuntary medication of a patient described with the symptoms set forth in this finding. Rather Dr. Kantar testified that there was a specific patient with these symptoms after the temporary restraining order that in his professional judgment should have been forcibly medicated. Dr. Kantar thought such medication would eliminate the patient's delusions; he said nothing about reliev-

ing the delusions only temporarily. TR. 11 at 167-170 (Kantar).

214.) Many patients who sign voluntaries are not sufficiently dangerous to themselves or others nor are they sufficiently unable to care for themselves to warrant an involuntary commitment by a court. (D—Olin TR. 51-27.)

DR-214.) See Defendants' Proposed Finding of Fact, J-426, 427.

215.) It is the defendant doctors policy and practice prior to the restraining order to involuntarily or forcibly medicate conditional voluntary patients, when they were calm and not in a state of emergency. This policy and practice was based on the doctors' assumption that voluntary patients, once admitted, could not refuse medication as long as they remained a voluntary patient in the hospital. (D—Olin TR. 51-115, 116, lines 7-10; 51-18, 19, 20, 21, 22, 23, 24. D—*SEIL* TR. 58-79, TR. lines 9-19; 58-82, lines 17-25; 58-83, lines 1-9. D—*GILL* TR. 66-64, 65, 66, 75, 76, 77, 78. See also TR. 51-43, 44, for admission by counsel in regard to defendants' policy and practice. P—Golder TR. 7-51, D—*KANTAR* TR. 12-131, 132, 133, 134.)

DR-215-215b.) Plaintiffs' cites in this finding support only the proposition that defendants considered themselves legally entitled to forcibly medicate voluntary patients when in their discretion such medication was appropriate. They in no way indicate that defendants forcibly medicated patients in non-emergencies.

215a.) It was the policy and practice of the doctor to forcibly or involuntarily medicate a conditional voluntary patient in a non-emergency situation, based on the patient admitting himself to the hospital and agreeing to be treated, even though at the time the patient signed the voluntary the doctor believed the patient was incompetent. It was the doctors position that as long as the voluntary patient remained in the hospital, the patient abandoned their right to refuse. (D—Olin TR.

51-18, 19, 20, 21, 22, 23, 24; 51-115, 116, 117, 118. D—*KANTAR* TR. 12-124, 125, 126, 127, 128, 129, 130, 131. D—*GILL* TR. 66-75, 76; 66-77, lines 4-9. D—*SEIL* TR. 58-79; 58-82, lines 23-25; 58-83, lines 1-9. P—Golder TR. 7-51.)

215b.) It was the policy and practice of the doctors to forcibly or involuntarily medicate a conditional voluntary patient in a non-emergency situation, based on the patient admitting himself to the hospital and agreeing to be treated, even though at the time the patient signed the voluntary the doctor believed the patient was incompetent. It was the doctors' position that as long as the voluntary patient remained in the hospital the patient abandoned their right to refuse. (D—Olin TR. 51-18, 19, 20, 21, 22, 23, 24; 51-115, 116, 117, 118. D—*GILL* TR. 66-75, 76; 66-77, lines 4-9. D—*SEIL* TR. 58-79; 58-82, lines 23-25; 58-83, lines 1-9. P—Golder TR. 7-51. See also TR. 51-43, 44, for admission by Counsel in regard to defendants' policy and practice. D—*KANTAR* TR. 12-124, 125, 126, 127, 128, 129, 130, 131.)

216.) The defendants policy and practice was to involuntarily or forcibly medicate voluntary and involuntary patients who refused their medication, even if the only consequence of their refusal was the possibility they may be assaultive in the non-immediate future. (D— See admission of Counsel TR. 1-77, lines 20-25; 1-78, lines 1-4. D—*GILL* TR. 66-64, 65, 66; 66-75, 76, 77, 78.)

217.) It was the general policy and practice of the doctors to forcibly or involuntarily medicate patients with antipsychotic drugs who refused their medication and were calm at the time of refusal and were not in a state of emergency. (D—Green TR. 61-70, lines 12-25; 61-71, lines 1-2, 5-6; 6-14, lines 21-23; 61-72, lines 7-10. P—Keller TR. 28-90, line 25; 28-91; 28-92; 28-93; 28-94. D—*KANTAR* TR. 13-35, lines 9-12, 19-22; 13-36, lines 14-17; 11-154, lines 22-25; 11-155, lines 1-7; 11-157; 11-158; 11-159; 11-128, lines 15-21. D—*GILL* TR. 64-48, lines 10-17; 64-55; 66-75, 76, 77, lines 4-9. P—*BYBEL*

TR. 39-15, lines 4-8. P—Franceen TR. 20-45, 46, 47, 48, 49, 50, 51, 52, 53, 54. P—Cariello TR. 22-7, 8, 10, 11, 12; 24-14, lines 12-25; 22-15, lines 1-3. P—Golder TR. 7-51. D—Opening Statement—admission of defendants' counsel TR. 1-76, lines 15-25; 1-77, lines 1-7.)

218.)The defendants policy and practice was to involuntarily or forcibly medicate voluntary and involuntary patients in the hospital, merely because they were patients in the hospital. (D—Olin TR. 51-37, 38, 32, 33. D—*GILL* TR. 66-64; 66-75, 76, 77, lines 4-9, 78; 66-65, 66; 65-109, 110; 64-51, 52. See admission of counsel TR. 51-32, lines 3-5. D—Green TR. 61-70, lines 12-25; 61-71, lines 1-2, 5-6; 6-14, lines 21-23; 61-72, lines 7-10. D—*KANTAR* TR. 11-128, lines 15-21. P—*BYBEL* TR. 39-15, lines 4-8. P—Keller TR. 28-90, line 25; 28-91; 28-92; 28-93; 28-94. P—Franceen TR. 20-45, 46, 47, 48, 49, 50, 51, 52, 53, 54. P—Cariello TR. 22-7, 8, 10, 11, 12; 24-14, lines 12-25; 22-15, lines 1-3. P—Golder TR. 7-51. D—Opening Statement of Admission of Counsel TR. 1-76, lines 15-25; 1-77, lines 1-7.)

DR-218.) See Defendants' Response to Plaintiffs' Proposed Finding (Medication—General), #210.

None of the defendants', defendants' witnesses nor defendants' counsel testified that the defendants' policy and practice was to involuntarily or forcibly medicate patients "merely because they were patients in the hospital." Dr. Olin did acknowledge that most patients are so psychotic at state hospitals that the doctors would be justified in forcibly medicating them. Tr. 51 at 32, 33 (Olin). Dr. Gill testified that if someone needed to be hospitalized at a state hospital, the doctors should have the right to forcibly medicate him. Ms. Green testified on the pages cited to no more than that patients were forcibly medicated only in emergencies, although emergency is something different than the standards for which seclusions may be used. On the pages cited, Dr. Kantar testified that a patient would be forcibly medicated if they

needed treatment. Defense counsel on the pages cited did no more than describe some circumstances when patients might have been forcibly medicated before the temporary restraining order. In fact, it was the policy of both the Austin and May Units to honor the refusal of patients whenever possible. See defendants' Proposed Findings, J-86.

219.) The defendants policy and practice was to involuntary or forcibly medicate voluntary and involuntary patients who refused their medication, even when the only consequence of their refusal was to prolong their hospitalization. (See Proposed Finding #215.)

219a.) If a patient was hospitalized it was perceived by the doctors as constituting a sufficient emergency to forcibly or involuntarily medicate the patient. (D—*GILL* TR. 66-64.)

DR-219a.) Dr. Gill testified that given the emergencies that lead to hospitalization, he should have the right to forcibly medicate a patient. He also testified that he would not exercise this right merely because the person was hospitalized. Tr. 66 at 64-65 (Gill). To exercise this right, Dr. Gill would need a situation constituting a psychiatric emergency, defined in Defendants' Proposed Findings, J-97-107.

219b.) It was the policy and practice of the doctors to involuntarily or forcibly medicate a patient when the doctors believed the consequence of the patient's failure to take their medication would be that the patient would probably deteriorate mentally. (D—Green TR. 61-71; 61-72, lines 7-10. D—*SEIL* TR. 58-85.)

219c.) It was the policy and practice of the doctors to involuntarily or forcibly medicate a patient when the doctors believed the consequence of the patients' failure to take their medication would be that the mental condition of the patient would probably deteriorate, and the physical condition of the patient would possibly deteriorate. (D—*SEIL* TR. 58-65, 66.)

220.) The civil rights form provided to patients and posted on the wards of the hospital did not accurately describe the

rights of patients, since patients did not have a right to refuse treatment. (P—*BYBEL* TR. 39-20, 21, 22. D—*KANTAR* TR. 11-130, lines 17-20; 11-132, lines 6-10; 11-136, 137; 11-138, lines 1-6. Plaintiffs Exhibit #3.)

221.) The negative effect of a misleading rights form is medically foreseeable. The form itself may cause anxiety in patients. (D—*KANTAR* TR. 11-13, lines 6-9.)

DR-221.) Dr. Kantar did not testify that the negative effect of a misleading rights form is medically foreseeable. He testified that a misleading form may stir anxieties, Tr. 11 at 135 (Kantar), but that he did not have an opinion of what the effect of a patient reading the form would necessarily be. Tr. 11 at 132 (Kantar). Dr. Kantar did note that patients feel reassured when they know that their psychotic behavior can be controlled. Tr. 11 at 133 (Kantar).

222.) The doctors' decisions to forcibly medicate or seclude patients was not affected by the facilities, staff or resources at the Austin Unit. (D—*GILL* TR. 65-121, 122, lines 1-7, 19-24.)

DR-222.) Dr. Gill specifically testified that on some occasions lack of staffing can affect the need to seclude or forcibly medicate a patient. Tr. 66 at 35-36 (Gill). See also Proposed Findings K-97-103.

223.) Prior to April 30, 1975, physicians denied patients who were able to make rational decisions, requests or demands to be removed from their medication or have the type or dosage of medication changed even though the patient complained of certain adverse effects caused by the medication. (D—*OSBORNE, KAHN, KANTAR, MALAMUD, POMERANTZ, SCHILDKROUT, SEIGEL, SZLYK, TURNQUEST, GILL, SEIL* First Set of Admissions #75.) (Plaintiffs' Exhibit 34.)

224.) Prior to April 30, 1975, physicians denied patients who were able to make rational decision, requests or demands to be removed from their medication or have the type of dosage or medication changed in circumstances in which the physician

considered that the medication was benefitting the patient psychologically even though the patient complained of adverse side effects. (D—*OSBORNE, KAHN KANTAR, MALAMUD.*

224a.) When a patient was resisting treatment, and the doctor believed that medication was necessary for sedation the doctors medicated the patients without their consent. (D—*GILL* TR. 11-138, lines 20-25; 11-139, lines 1-8.)

DR-224a.) Dr. Gill did not testify that a patient would be medicated if resisting treatment, but that a patient would be medicated if refractory, thus, resistant to other treatments. Tr. 11 at 138-139 (Gill).

224b.) If a patient didn't want to be treated but the doctors believed the patient was incapable of leaving the Austin Unit or managing their affairs while outside the hospital the patient would be involuntarily treated. (D—*KANTAR* TR. 11-128.) *POMERANTZ, SCHILDKROUT, SEIGEL, SZLYK, TURNQUEST, GILL, SEIL* First Set of Admissions #76.) (Plaintiffs' Exhibit 34.)

225.) Prior to April 30, 1975, at times physicians did not attempt to utilize other alternative medications or forms of treatment after the patient had complained of various side effects to the physician or staff. (D—*KAHN, KANTAR, MALAMUD, MAZMANIAN, SCHILDKROUT, SEIGEL, SZLYK, TURNQUEST, GILL, SEIL* First Set of Admissions #77.) (Plaintiffs' Exhibit 34.)

(IX.) COMPETENCY OF PATIENTS

226.) Psychotic individuals are not uniformly impaired in all aspects of their personality functions, or more technically speaking ego-functioning, and although by definition their relationship to reality is impaired, there are some aspects of reality which they can accurately assess; that is, there are very few individuals who are so flagrantly and completely psychotic that they can't understand any aspect of their relationship with their environment. (P—Messinger TR. 33-99.)

DR-226-228.) See generally Defendants' Proposed Findings J-406-433.

227.) Most psychiatric patients, especially those remitted patients receiving maintenance therapy, can appreciate the risks involved from receiving antipsychotic medication and are competent to make the decision regarding future treatment. (Plaintiffs Exhibit #31. "Sovner, DiMascio, Randolph and Berkowitz at page 177.)

DR-227.) Sovner, DiMascio, Berkowitz and Randolph limit their recommendation that patients be informed about tardive dyskinesia to competent patients. Tr. 65 at 17 (Pl. Ex. #31. Sovner, DiMascio, Berkowitz and Randolph, "Tardive Dyskinesia & Informed Consent", p. 176).

DR-227.) Sovner, DiMascio, Berkowitz and Randolph specifically state that acutely psychotic patients and some chronic schizophrenic patients are unable to appreciate the risks involved from receiving antipsychotic medication and are incompetent to make the decision regarding future treatment. Pl. Ex. 31, p. 177. The authors also state that "[i]f a patient is acutely psychotic and has Tardive Dyskinesia, we would institute neuropleptic drug therapy without written consent, because it is an emergency." Pl. Ex. 31, p. 176.

228.) Dr. Peter Randolph, one of the co-authors of Plaintiffs' Exhibit #31 is the area director of the Bay Cove Mental Health Center, the umbrella organization of the Austin Unit. (P—Sovner TR. 70-50, lines 10-23.)

(X.) RULES AND REGULATIONS GOVERNING COMPETENCY

Legal Capacity of Persons Admitted or Committed:

229.) No person shall be deemed to be incompetent to manage his affairs, to contract, to hold professional or occupational or vehicle operators licenses or to make a will solely by reason of his admission or commitment in any capacity to the treatment or care of the department or to any public or private

facility, nor shall departmental regulations restrict such rights. (M.G.L. c. 123, §25.)

Civil Rights

230.) No person shall be deprived of the right to manage his affairs, to contract, to hold professional, occupational or vehicle operator's licenses, to make a will, to marry, to hold or convey property, or to vote in local, state, or federal elections solely by reason of his admission or commitment to a facility except where there has been an adjudication that such person is incompetent, or when a conservator or guardian has been appointed for such person. In the event of conservatorship, a patient's civil rights may be limited only to the extent of the conservator's adjudicated responsibility. (D.M.H. Regulations §221.02.) (Stip. pp. 17, 18.)

Evaluation of Competency:

231.) For each periodic review, the legal competency of a patient shall be evaluated by the senior reviewing clinician in terms of whether he is able to manage rationally the ordinary affairs of life, and whether he is in need of guardianship or conservatorship for his protection. If the question of a patient's competency is raised by periodic review, or pursuant to G.L. c. 123 SEC. 26, if the superintendent or other head of the facility has reason to believe that a person who has been under the care of the Department as an in-patient for more than six months, who is not under guardianship or conservatorship, is unable to care for his property, he shall promptly notify said person's nearest living relative and recommend that the necessary steps be taken for the appointment of a guardian or a conservator. If the patient has no living relative, the superintendent or other head of the facility may file a petition as petitioner for the appointment of a guardian or conservator. (D.M.H. Regulations SEC. 222.05) (Stip. p. 19.)

Adjudication of Competency:

232.) Under M.G.L., c. 123, §26, or as part of the periodic review conducted under M.G.L., c. 123, §4 and Part 222, or under §220.02(b), the superintendent or his designee shall give notice to the patient and his nearest living relative that a clinical recommendation has been made that there be an adjudication of the competency of such patient. The facility shall also take reasonable means to apprise persons having dealings with such patient that such recommendation has been made, or that an adjudication of competency of such patient is pending. (D.M.H. Regulations §221.06.) (Stip. p. 18.)

(XI.) PRACTICES OF DOCTORS IN REGARDS TO THE ISSUES OF COMPETENCY

233.) At the periodic review, the legal competency of the patient was not evaluated by the Senior reviewing clinician in terms of whether or not the patient was able to manage rationally the ordinary affairs of life and whether he was in need of guardianship or conservatorship for his protection. (Statement of Agreed Facts for Injunctive Relief No. 10.) (Stip. p. 352.)

234.) Many of the defendant-doctors did not know how the guardianship procedure operated in Massachusetts. (D—*GOLDBARG, MALAMUD, POMERANTZ, SEIL, SEIGEL, TURNQUEST, OSBORNE*—2nd set of admissions, No. 55) (Plaintiffs' Exhibit 34.)

235.) It was not the policy or practice of The Austin and May Unit to seek a guardianship for patients whom the doctors considered to be incompetent to make rational decisions about their own treatment. (D—*KAHN, KANTAR, MALAMUD, POMERANTZ, SCHILDKROUT, SEIL, SEIGEL, SZLYK, TURNQUEST, GILL, GOLDBARG, OSBORNE*—2nd set of admissions, No. 54) (Plaintiffs' Exhibit 34.)

236.) Involuntary patients whom the defendant doctors believed were not able to make rational decisions had been medicated forcibly against their will and without their in-

formed consent when there was not a serious threat of or as a result of extreme violence, personal injury, or attempted suicide. (D—*KAHN, KANTAR, MALAMUD, MAZMANIAN, POMERANTZ, SCHILDKROUT, SEIL, SEIGEL, SZLYK, TURNQUEST, GILL*—2nd set of admissions, No. 2, Plaintiffs Exhibit No. 34.)

237.) Prior to April 30, 1975, doctors ordered or authorized the forcible or involuntary medication of incompetent but non-court adjudicated incompetent patients in non-emergency situations, without attempting to petition a court of competent jurisdiction for an appointment of a guardian. (D—*OSBORNE, KAHN, KANTAR, MALAMUD, SCHILDKROUT, SEIL, SEIGEL, TURNQUEST, SZLYK*—1st set of admissions, No. 74, D—*KANTAR*, TR. 12-114, 115) (Plaintiffs Exhibit 34.)

238.) Prior to April 30, 1975, a number of patients whom the doctor believed were unable to make rational decisions were medicated against their will or without their informed consent as part of a planned therapeutic program for over 2 years without the doctor recommending or filing a petition in a court of competent jurisdiction to adjudicate the patient incompetent. (D—*GOLDBARG*—1st set of admissions, No. 35) (Plaintiffs' Exhibit 34.)

(XII.) THE INVOLUNTARY OR FORCIBLE MEDICATION OF PATIENTS IN NON-EMERGENCIES IS NOT A TREATMENT AND IS UNACCEPTABLE MEDICAL PRACTICE

239.) The pharmacological aspects of antipsychotic are specific, but the therapeutic response to the drugs are non-specific: (P—DiMascio, TR. 29-31, lines 21-25; 29-32; 29-33; 29-34, lines 1-3. P—Messinger, TR. 31-50, 51.)

DR-239.) (1) See also Defendants' Proposed Finding J-180. (2) Dr. DiMascio did not testify that the therapeutic response to drugs is non-specific, but that factors other than the phar-

macological properties of the drug can influence a patient's response to medication. Tr. 29 at 31-34 (DiMascio).

DR-239-263.) See generally Defendants' Proposed Findings, J-256-261, 275-281.

240.) The success of any antipsychotic drug in relieving mental distress substantially depends on the patient's attitude to the drug when it is administered. The patient's attitude towards the drugs, towards the physician and the whole social setting in which the drug is administered has profound effect on the efficacy of the drug. (D—*KANTAR*, TR. 14-30, lines 10-13, 14-25; line 25, 14-26; lines 1-11, 11-145; lines 22-25, 11-146; line 1; Stip. No. 27. TR. 14-25; line 25, 14-26, lines 1-8; P—Whitaker, TR. 34-13; lines 15-25; P—Messinger, TR. 31-50, 51; P—Rundle, TR. 30-65, lines 20-25, 30-66; lines 1-5; D—*SEIL*, TR. 58-95, 58-96; lines 9-21 in regards to the plaintiff *RUBY ROGERS*; P—DiMascio, TR. 29-31; lines 21-25, 29-32, 29-33, 29-34; lines 1-3.)

DR-240.) Dr. DiMascio not only did not testify that the success of an antipsychotic medication substantially depends on the patients attitude toward the drug and that these attitudes have a profound effect on the efficacy of the drug, he specifically testified that the effect of "known specific drug factors" varies with different patients. Tr. 29 at 31-32 (DiMascio). Dr. Kantar testified to no more than that known specific factors can influence whether a drug will be beneficial or detrimental. Tr. 14 at 25, 30 (Kantar). Dr. Seil testified to no more than that Rubie Rogers had an antipathy to Haldol. Tr. 58 at 95-96 (Seil). Whitaker testified to no more than that allowing a patient to participate in his treatment and refuse treatment has, in his opinion, a therapeutic effect. Tr. 34 at 13 (Whitaker).

241.) The concept of the therapeutic alliance is central and essential to the treatment of emotionally disturbed psychiatrically disabled patients. The essence of the therapeutic alliance is the trusting relationship in which there

is a two-way communication between the therapist and patient. This alliance must be established and maintained in order for treatment to be able to achieve behavioral and emotional changes. (D—*SZLYK*, TR. 6-16, lines 23-25, 6-17; lines 1-10, 6-22; lines 1-6, 6-23, lines 4-11; P—Whitaker, TR. 34-4, lines 3-11, 34-7; lines 9-25, 34-8; lines 1-3; 34-19; lines 6-14, 34-13; lines 15-25, 34-14; lines 1-4; D—*SEIL*, TR. 58-95, 58-96, lines 9-21 in regards to the plaintiff *RUBY ROGERS*: P—Messinger, Tr. 31-47, 48, 49, 50, 31-30; Stip, No. 3, agreed statement of facts for injunctive relief; D—*GILL*, TR. 65-79, lines 6-13; P—Rundle, TR. 30-65, lines 20-25, 30-66; lines 1-5.)

242.) Therefore, the physician must take into account not only the pharmacological effect of the antipsychotic drug, but must take into account the effect the administration of the drug will have on the establishment or maintenance of a therapeutic alliance. (P—Messinger, TR. 31-47, 31-56, 57. See proposed finding No. 241.)

243.) To disregard patients' subjective complaints about the antipsychotic drug they are receiving, or ignoring patient's requests to change the medication serves to invalidate what the patient is feeling and reinforces patients' feelings of incompetence. (P—Messinger, TR. 31-47, 31-56, 57; P—Whitaker, TR. 34-14, lines 1-4.)

DR-243-247.) (1) The forcible and involuntary medication of patients does not cause feelings of dependency and lack of responsibility in patients. Tr. 66 at 33-34 (Gill). (2) The negative side of forcible medication is far outweighed by the positive side in the eyes of the patient. Tr. 57 at 103 (Brill). (3) Involuntary and forcibly medicating a patient does not lessen a patient's confidence in himself. What lessens the patient's confidence in himself is a long bout of loss of control and a feeling that he is out of control and he is against the world and the world is against him. Tr. 57 at 103 (Brill). It is reassuring to a psychotic patient to know that he can be positively influenced by medication. Tr. 57 at 104 (Brill).

(4) Forcibly medicating a patient, when done properly, does not destroy a therapeutic relationship between the doctor and the patient. Tr. 57 at 104 (Brill).

244.) When the staff disregard a patient's subjective complaint about their medication, or ignore a patient's request to change their medication, patients view the medical personnel as not only unresponsive to their personal needs but as actually creating distress. (P—Messinger, TR. 31-47, 31-56, 57.)

245.) Involuntarily administered antipsychotic medication undercuts rather than fosters patients' needs to control their behavior, to trust their own judgement, and to validate their own feelings, such as their subjective response to antipsychotic drugs. (P—Messinger, TR. 31-53, 31-56, 57, 58; D—*Gill*, Tr. 65-79, lines 14-25.)

DR-245.) Dr. Gill did not make any statement attributed to him in this finding. He did state that to have a guardian appointed undercuts the efforts to give patients an active role in their own treatment. Tr. 65 at 79 (Gill). Dr. Gill specifically testified that forcible medication gives the patient enough structure to participate in other therapies. Tr. 66 at 30 (Gill).

246.) During institutional care, many patients become infantalized often caused by a pervasive staff attitude that patients are unable to make their own decisions. This attitude, when translated into how the staff relates to patients, reinforces patients' own sense of incompetence, dependency, and lack of self-respect. (P—Messinger, TR. 31-52, 31-56, 31-57, 31-58, 31-71, 31-67.)

247.) In addition, it increases patients' dependency on the staff for decision making, often resulting in patient passivity and ultimately institutionalization. (P—Messinger, TR. 31-52, 31-53, 31-71, 31-67.)

248.) Furthermore, forcible medication often makes patients feel demeaned and humiliated, by having to be physically restrained, pants removed, injected with antipsychotic drugs through a hypodermic needle in the buttocks, at times in full

view of other patients or staff of the opposite sex, (Statement of agreed facts for injunctive relief, No. 4, D—*KANTAR*, TR. 14-44, lines 18-25, 14-45; line 6, P—Messinger, TR. 31-58.)

DR-248.) The Statement of Agreed Facts states no more than that at times, patients were forcibly medicated in view of other patients, and that forcible medication required pulling a patient's pants down or skirt up. Dr. Kantar stated only that intramuscular medication is given in the buttocks, at times in view of other patients, although he could not think of a particular instance. Tr. 14 at 44-45 (Kantar).

In fact, Dr. Kantar testified that when patients are in need of forcible medication, other feelings outweigh any embarrassment from receipt of the needle in the buttocks. Tr. 14 at 45-46 (Kantar).

249.) Intramuscular injection of a phenothiazine is often extremely painful. (D—*OSBORNE*, TR. 34-10, Lines 1-17; P—Whitaker, TR. 36-51, lines 5-12, 36-17, 18, 36-52; lines 22-24.)

DR-249.) There is no evidence that the receipt of antipsychotic medication by injection is any more painful than the receipt of any medication by injection. Tr. 36 at 52-53 (Whitaker).

250.) Patients in The May Unit generally feared hypodermic needles and the procedure for forcibly medicating them. (D—*OSBORNE*, TR. 34-10, lines 1-17; D—*GOLDBARG*, D—*CACCIOLA*, D—*OSBORNE*, Defendants response to plaintiffs request for admissions, No. 4. D—Erban TR. 40-63, lines 9-12.)

DR-250.) All the defendants other than the four residents cited in this finding disagreed that patients generally feared hypodermic needles. Response to plaintiffs request for admission, No. 4, for all other defendants. Ms. Erban stated only that Betty Bybel was frightened of any body contact, including injection with a needle. Tr. 40 at 63 (Erban).

251.) Anxiety will increase in patients who receive medication forcibly by hyperdermic needle. (D—*KANTAR*, TR. 14-48, 14-43, lines 23-25; P—Kauff, TR. 8-113, lines 16-19;

P—Demers, TR. 2-10, lines 15-22; quoting *DONNA HUNT*.)
DR-251.) None of the cites given by plaintiffs support this finding. Dr. Kantar testified only that given the hypothetical that Colleran and Bybel feared injection with a needle, then one would conclude that their receiving an injection would cause them anxiety. Kantar specifically noted that the medication they received would reduce their anxiety. Tr. 14 at 48 (Kantar). The citation given to support Kauff's statement is unrelated to forcible medication. Tr. 8 at 113, lines 16-19 (Kauff). Christine Demers, who was only an attendant, testified only that in her opinion Donna Hunt was petrified of receiving injections of medication. Tr. 2 at 10 (Demers).
252.) Many times when the nursing staff administered medication forcibly, a patient's pants would be pulled down, or a patient's dress would be pulled up. (D—*KAHN, KANTAR, MALAMUD, POMERANTZ, SCHILDKROUT, SEIGEL, TURNQUEST, GILL, GOLDBARG, CACCIOLA, OSBORNE, SEIL*—1st set of admissions, No. 26.) (Plaintiffs Exhibit 34.)
253.) It is a violation of a patient's dignity to be involuntarily medicated in a non-emergency. (D—*KANTAR*, TR. 11-146, lines 2-6.)
DR-253.) Dr. Kantar did not testify that it is a violation of a patient's dignity to be involuntarily medicated in a non-emergency. He testified that it could be and this possibly was one factor that should be considered when deciding whether to involuntarily medicate. He testified in answer to the previous question that at times the doctor has a responsibility to intervene. Tr. 11 at 145-146 (Kantar).
254.) Common dignity mandates respecting a patient's wishes to be involuntarily medicated. (D—*KANTAR*, TR. 11-145, lines 22-25; 11-146, line 1.)
DR-254.) Dr. Kantar did not testify that common dignity mandates respecting a patient's wishes not to be involuntarily medicated. Rather, in response to a question as to why it was

his personal policy to honor a patient's request not to be involuntarily medicated in non-emergencies, Dr. Kantar answered that a patient is a person whose wishes should be respected when possible, that he honors requests in non-emergencies as a common dignity, unless for other reasons he has a responsibility to intervene. Tr. 11 at 145, lines 22-25; Tr. 11 at 146, line 1 (Kantar).

255a.) For patients to successfully reintegrate into the community, they must reattain their self-respect and independence. While hospitalized, it is therapeutically essential for patients to be allowed and encouraged to make decisions about their own treatment, as well as other important decisions in their lives. (P—Messinger TR. 31-67, 68. D—*SCHILDKROUT* TR. 43-108,109,110,111,112.)

256.) Providing the mental patient with the right to refuse medication and the right to participate in the actual formulation of their treatment plan in non-emergencies is itself therapeutic for the patient. (P—Messinger TR. 31-66, 67. D—*SCHILDKROUT* TR. 43-108,109,110,111,112. D—Press Tr. 47-95,96.)

256a.) "As mentioned above, Boston Psychopatic and Solomon Center share a common philosophy of clinical and social management. This philosophy is based on the idea that the majority of mental illnesses, especially the most severe, are largely self-limiting in nature if the patient is not subjected to demeaning experiences or loss of rights and liberties. Therapeutic management consists first and foremost of removing these negative influences and replacing them with a positive attitude of respect for the patient's needs for human companionship and interest-holding activity." (P—"Bochoven and Solomon" TR. 37-22, lines 8-25; 37-23, lines 1-12, 37-24, lines 17-25; 37-25, lines 1-7.)

257.) The Boston Psychopathic Hospital is the Massachusetts Mental Health Center. (P—DiMascio TR. 37-24, lines 11-16.)

258.) All of the research studies on the efficacy of

psychotropic medication and anti-psychotic medication had been conducted on voluntary subjects over an extended period of time using various control measures. There is no such research on unwilling subjects. (P—Whitaker TR. 34-7, line 25; 34-8, lines 1-4; D—Brill Tr. 57-115, lines 10-25; 57-116, lines 1-21; P—Messinger TR. 31-51.)

DR-258&259.) There are studies which have shown anti-psychotic medication to be effective even though the patients were incapable of giving informed consent. Tr. 35 at 76 (DiMascio).

259.) In discussing and determining the risk-benefit ratio and efficacy of antipsychotic drugs, involuntariness is a crucial variable. (P—Whitaker, 34-8.)

260.) To determine the efficacy of antipsychotic drugs on an involuntary patient population, one would have to use patient population that does not want to receive anti-psychotic medication. (See proposed findings 239-259; P—Messinger 31-52; P—Whitaker TR. 34-9, lines 8-24.)

261.) "The American Psychiatric Association is aware of the possibility that the right to adequate care and treatment may be misunderstood and even be used in some cases in a coercive manner. We therefore wish to clearly indicate that our concern is that adequate care and treatment be available. As is the practice generally in medicine, the patient's informed consent for treatment is required except for emergency situations." (P—"American Psychiatric Association," TR. 34-5,6; see also Plaintiffs Exhibit 31, "Sovner, DiMascio, Berkowitz and Randolph," at p. 172; see also Position Statement of Adequacy of Treatment by the American Psychiatric Association, in 1967 on 52-95, lines 8-14.)

DR-261.) The APA position statement approved treating a patient against his will if there had been procedural safeguards such as a court commitment or a hospital review. It further noted that whether any procedural safeguards should be applied required further study. Tr. 36 at 40 (American

Psychiatric Association, "Position Statement on the Right to Adequate Care and Treatment for the Mentally Ill and Mentally Retarded", Am. J. of Psych., March, 1977). See Defendants' Proposed Findings, J-123-124 for a further explanation of the APA's position regarding involuntary treatment.

262.) It is a basic principle of psychiatric training and psychiatric practice that a patient should not be involuntarily medicated in a non-emergency. (D—*SZLYK* TR. 6-21, lines 16-25; 6-22, lines 1-6; "Sovner, DiMascio, Berkowitz, and Randolph," Plaintiffs Exhibit 31 at p. 172; P—DiMascio TR. 37-37, lines 15-25, 37-38, lines 1-2; P—"American Psychiatric Association" TR. 34-5, 6. D—Press TR. 47-95, 96. D-*SCHILDKROUT* TR. 43-108, 109, 110, 111, 112.)

DR-262.) Dr. Schildkrout did not testify that it is a basic principle of psychiatric training and psychiatric practice that a patient should not be involuntarily medicated in a non-emergency. Drs. Schildkrout and Press said only it was their practice not to involuntarily medicate in a non-emergency (as it was the practice of all the defendants in this case [Defendants' Proposed Finding, J-86]). Tr. 43 at 108-112 (Schildkrout); Tr. 47 at 95-96 (Press). The exact American Psychiatric Association statement is cited in Plaintiffs' prior finding, #261, and has been placed in context in Defendant's Response to that finding. Dr. DiMascio simply stated that in his opinion the doctrine of informed consent should apply to the competent psychiatric patient when a significant risk of serious adverse reaction exists. He testified that he does not know how to handle informed consent with the incompetent individual. Tr. 37 at 37-38 (DiMascio).

263.) Forcefully or involuntarily medicating patients when there is not a serious threat of or as a result of extreme violence, personal injury or attempted suicide was unacceptable medical practice in 1973-1975 and is unacceptable medical practice today. (P—Messinger, TR. 31-57, 31-43, 44, 45, 46; D—*SZLYK*, TR. 6-16, lines 23-25, 6-17, lines 1-16,

6-21; lines 16-25, 6-22; lines 1-6; 6-23; lines 4-11; P—Whitaker, TR. 34-5, 6, 7, 34-19; lines 6-14; P—"American Psychiatric Association" TR. 34-5, 6, Plaintiff's Exhibit 31, "Sovner, DiMascio, Berkowitz, Randolph," p. 172. D-Press TR. 47-95, 96. D-*SCHILDKROUT* TR. 43-108, 109, 110, 111, 112. D—*CACCIOLA* TR. 56-30, 31.)

DR-263.) None of the persons and authorities cited in this finding state that forcefully or involuntarily medicating patients when there is not a serious threat of or as a result of extreme violence, personal injury or attempted suicide was unacceptable medical practice in 1973-1975 and is unacceptable practice today. The only person or authority cited in this finding ever to mention the words unacceptable medical practice or their equivalent is Dr. Messinger, and he only testified that in his opinion it was unacceptable medical practice to have allegedly forcibly and involuntarily medicated Rubie Rogers in non-emergencies. See cites to Plaintiffs' Finding. Dr. Whitaker, in fact, testified that as a non-doctor he was unable to reach conclusions regarding acceptable "medical" care. Tr. 38 at 31, 39 (Whitaker).

264.) Involuntary and forcible medication should only be used as a last resort. Forced or involuntary medication should only be used as a restraining mechanism. It should only be used as a restraint if the patient constituted a serious threat of harm to self or others, and the medication would serve to terminate the emergency. (P—Messinger, TR. 31-60, 31-43; Plaintiffs Exhibit 26—Revised Department of Mental Health Regulations concerning the use of medication involuntarily.)

DR-264.) The Department of Mental Health regulations merely set forth the time that medications should be used as a restraint. They take no position regarding when medication can be given involuntarily or forcibly, not as a restraint. See specifically Plaintiffs' Proposed Finding (Medication—General), 266b. Involuntary and forcible antipsychotic medication is rarely, if ever, a restraint. See Defendants' Proposed Findings, K-221-229.

(XIII.) *RULES AND REGULATIONS GOVERNING MEDICATIONS USED AS A CHEMICAL RESTRAINT*

265.) M.G.L. c. 123 SEC. 1, 21 in relevant portion defines "restraint" and sets the rules to govern the use of the conditions in which medication may be used as a chemical restraint:

a.) "Restraint", bodily physical force, mechanical devices, chemicals, confinement in a place of seclusion other then the placement of an inpatient or resident in his room for the night, or any other means which unreasonably limit freedom of movement, (M.G.L § 1.)

b.) In the case of inpatients or residents in facilities of the department, restraint may be used only in cases of emergency such as the occurrence of, or serious threat of, extreme violence, personal injury, or attempted suicide; provided, however, that written authorization for such restraint is given in advance by the superintendent or by a physician designated by him for this purpose or if the superintendent or the designated physician is not available, nonchemical means of restraint may be used; provided, however, that said use is reported to the superintendent or to the designated physician within eight hours of said use. Any use of restraint shall be reviewed at least every eight hours by said superintendent or physician, who shall authorize in writing its continuation or cessation and shall make a written record of the reasons for any such use and of his review. (M.G.L. § 21.)

266.) The Department of Mental Health Regulation, regulating the use of medication as chemical restraints are as follows: (Stip. pp. 20,22.)

a.) *Use of restraint and seclusion*

Restraint or seclusion of patients may be used only in emergency situations where there is the occurrence of serious threat of extreme violence, personal injury, or attempted suicide. (D.M.H. Regulation 223.02.)

b.) *Definition of restraint*

Restraint shall mean:

1.) mechanical restraints such as anklets, wrislets, muffs, mitts with lock buckles or waist straps, head straps, protection sheets, simple sheets when used for restraint, or any other device interfering with free (voluntary) movement; and

2.) chemical and therapeutic restraints except when these are used as a part of a planned medical psychotherapeutic program. (D.M.H. Regulation 223.03.)

c.) *Advance written authorization required*

Written authorization for restraint or seclusion shall be given in advance by the superintendent or other head of the facility or by a physician designated for this purpose. The person placing the patient in restraint or seclusion shall also sign such authorization form. If the superintendent or other head of the facility or his designated physician is not available, non-chemical means of restraint may be used, provided that such use is reported to the superintendent or other head of the facility or the designated physician by the person authorizing such non-chemical restraint within eight hours. (D.M.H. Regulation, §223.05.)

d.) *Eight Hour Limit*

No order for seclusion or restraint shall be used for a period longer than eight hours. Patients in seclusion shall be visited at least once every hour by designated ward staff. Patients in mechanical restraint shall be relieved from such restraint at least once in every two hour period by designated ward staff except during the hours between 8:00 a.m. and 8:00 p.m. when such interval shall be no more than four hours. (D.M.H. Regulation, §223.06.)

e.) *Review of Restraint and Seclusion*

Any use of restraint or seclusion shall be reviewed at least every eight hours by the superintendent or other head of the facility or his designated physician, who shall authorize in writing its continuation or cessation, and who shall make a

written record of the reasons for the use of restraint or seclusion and of his review of such use on Departmental Form A-32. (D.M.H. Regulation § 223.07.)

f. *Records of restraint and seclusion*

a.) In each instance where a patient had been subject to restraint or seclusion, his case record shall include:

1.) the nature of the restraint;
2.) the reason for the restraint;
3.) the name of the person authorizing the restraint;
4.) the time the restraint was first administered and
5.) the time the restraint was removed.

b.) The superintendent or other head of a facility shall submit a monthly report to the Department, on forms prescribed by the Department, pertaining to restraint and seclusion practices in the facility.

c.) Every facility shall keep a record signed by the person or persons responsible for visiting a patient in the seclusion or relieving a patient from mechanical restraint immediately after visiting or relieving such patient.

d.) The facility shall keep all records and orders relating to restraint and seclusion as permanent records, so as to facilitate their review by the superintendent or other head of the facility, his designated physician, and the Department. (D.M.H. Regulation § 223.08.)

267.) The Department of Mental Health regulations revised to clarify the rules regarding restraint state that any medications given to patients involuntarily or forcibly is medication for chemical restraint and not treatment purposes, and therefore must comply with D.M.H. Regulation § 223.02 to 223.08. (Plaintiff Exhibit No. 26, D—*GILL*, 64-61, lines 12-21.)

(XIV.) *POLICY AND PRACTICE OF THE DOCTORS IN REGARDS TO USING MEDICATION P. R. N. AND AS A CHEMICAL RESTRAINT*

268.) Prior to April 30, 1975, PRN medication was used as a chemical restraint but its use as a restraint and the reasons and

circumstances for its use were often not placed on the DMH Restraint and Seclusion Forms; form A-32. (D—*MAZMANIAN, SCHILDKROUT, SZLYK, GOLDBERG, CACCIOLA*—1st set of admissions No. 60.) (Plaintiffs' Exhibit 34.)

DR-268.) While this proposition was admitted by the defendants, it was noted that the A-32 forms were not used because it was unclear when a PRN was being used as a restraint as opposed to when it was being used for the therapeutic purpose of letting a patient regain his control. There was a grey area and PRN medication was not considered a restraint except when used in exceptional dosages. When medication was used as a restraint, it was almost, if not always, accompanied by seclusion. Gill Response to Request for Admissions, First Set, #60; Seil Response to Request for Admission, First Set, #60.

DR-268-284.) See generally Defendants' Proposed Findings of Fact K-221-229. Also note that many of plaintiffs' findings in this section are based on evidence relative to only one or the other, but not both Units.

269.) Prior to the temporary restraining order, supervisory doctors never informed the staff to fill out the Department of Mental Health form A-32-72 when patients were forcibly medicated against their will in emergency situations. (Statement of Agreed Facts for Damages and Injunctive Relief #6.) (Stip. pp. 3, 4.)

DR-269.) A-32-72 forms were not filled out when patients were forcibly medicated because before the DMH regulations were changed after this lawsuit there was no indication that DMH desired any forms to be filled out when patients were forcibly medicated. The fact that a patient was forcibly medicated does not mean that the medication was used as a restraint. See Defendants' Proposed Findings K-221-229.

270.) Doctors did not fill out or sign the Department of Mental Health form A-32-72 when they medicated patients. (Statement of Agreed Facts for Damages and Injunctive Relief #9.) (Stip. p. 4.)

271.) Prior to April 30, 1975, it was not the general practice and policy of physicians to include in patients' records:

a.) the reasons and circumstances for the use of PRN medication (D—*GOLDBARG* First Set of Admissions #63), (Plaintiffs' Exhibit 34.)

b.) if and why the medication was used as a chemical restraint (D—*SZLYK, TURNQUEST, GOLDBARG* First Set of Admissions #63), (Plaintiffs' Exhibit 34.)

c.) the individual who determined that its use at that particular time was appropriate (D—*POMERANTZ, GOLDBARG, CACCIOLA, OSBORNE* First Set of Admissions #63), (Plaintiffs' Exhibit 34.)

d.) whether or not a physician was called prior to or subsequent to its use, or administration, (D—*KAHN, KANTAR, MALAMUD, MAZMANIAN, POMERANTZ,* SCHILDKROUT, SEIGEL, SZLYK, TURNQUEST, GILL, GOLDBARG, CACCIOLA, OSBORNE, SEIL First Set of Admissions #63) and, (Plaintiffs' Exhibit 34.)

e.) whether or not it was administered voluntarily or involuntarily (D—*KAHN, KANTAR, MALAMUD, MAZMANIAN, POMERANTZ, SCHILDKROUT, SEIGEL, SZLYK, TURNQUEST, GILL, GOLDBARG, CACCIOLA, SEIL* First Set of Admissions #63). (Plaintiffs' Exhibit 34.)

DR-271.) See Defendants' Proposed Findings of Fact, K-149-160.

272.) Prior to April 30, 1975, PRN medication had been used as a chemical restraint in circumstances where less restrictive alternatives would have appropriate to terminate the emergency, if: a.) more staff; b.) more male staff; or, c.) more resources were available in the hospital at the time. (D-*GOLDBARG, CACCIOLA, OSBORNE* First Set of Admissions #30.) (Plaintiffs' Exhibit 34.)

DR-272.) All the defendants other than the May Unit residents cited in this finding disagreed with the proposition

set forth in this finding. See Defendants' Responses to First Set of Admissions, ¶30.

273.) Physicians had PRN phenothiazine orders and PRN IM phenothiazine orders for many voluntary and involuntary patients. (Statement of Agreed Facts for Injunctive Relief ¶17.) (Stip. p. 353.)

274.) Phenothiazine IM "As necessary" or for agitation" pursuant to a PRN IM order at times has been renewed by physicians for the entire period of some patients' hospitalization. (Statement of agreed facts for injunctive relief only, No. 18.) (Stip. p. 353.)

275.) The physician's order or authorization for the use of phenothiazines PRN, consisted of instructions to administer PRN medication, "as necessary" or "for agitation." (D-*KAHN, KANTAR, MALAMUD, POMERANTZ, SCHILDKROUT, SEIGEL, SZLYK, TURNQUEST, GILL, GOLDBARG, OSBORNE, SEIL*—1st set of admissions No.56.) (Plaintiffs' Exhibit 34.)

276.) a.) There were no specific guidelines in the patients' records for the administration of phenothiazines pursuant to a PRN order for intramuscular injections, nor

b.) were there any indications how these orders were part of any treatment plan. (D-*KAHN, KANTAR, MALAMUD, POMERANTZ, SCHILDKROUT, SEIGEL, SZLYK, TURNQUEST, GILL, SEIL*—1st set of admissions No. 55.) (Plaintiffs' Exhibit 34.)

DR-276-283.) See Defendants' Proposed Findings, K-209-220, 200, 201, 205-207, 159.

277.) When the doctors ordered or authorized the administration of a PRN phenothiazine medication to be given "as necessary" or "for agitation," it was not the general practice or policy of the staff to call any physician when a nursing staff member decided that in a particular circumstance it was appropriate to administer the PRN medication either voluntarily or involuntarily. (D-*GOLDBARG, CACCIOLA,*

OSBORNE—1st set of admissions, No. 52.) (Plaintiffs' Exhibit 34.)

DR-277-278.) Nurses were given guidelines in addition to the doctor's order as to when to medicate a patient involuntarily. Tr. 13 at 11-12 (Kantar); see also Defendants' Proposed Findings, K-200, 201, 204-206.

278.) If a doctor ordered or authorized the administration of a PRN phenothiazine medication to be given "as necessary" or "for agitation" it was not the general practice or policy of the staff to call the physician who ordered or authorized the PRN medication when a nursing staff member decided that in a particular circumstance it was appropriate to administer the PRN medication either voluntarily or involuntarily. (D-*MAZMANIAN, POMERANTZ, GOLDBARG, CACCIOLA, OSBORNE*—1st set of admissions, No. 51.) (Plaintiffs' Exhibit 34.)

279.) When a nurse determined that in a particular circumstance it was appropriate to give a patient a PRN medication either voluntarily or involuntarily, he/she would check the physician order sheet to determine if a doctor authorized the administration of the medication for patients. (D-*KAHN, KANTAR, MALAMUD, POMERANTZ, SCHILDKROUT, SEIGEL, SZLYK, TURNQUEST, GILL, CACCIOLA, OSBORNE, SEIL*—1st set of admissions, No. 57.) (Plaintiffs' Exhibit 34.)

280.) In circumstances in which there was not a physician order, the nurse would telephone the doctor on call, who at times was not familiar with the particular patient, to authorize, through a verbal order, the medication of a patient pursuant to his/her PRN order. (D-*CACCIOLA*, D-*OSBORNE*—1st set of admissions, No. 58) (Plaintiffs' Exhibit 34.)

281.) When a doctor on call ordered or authorized a PRN medication, he/she was not required to physically or psychologically examine the patient;

a.) prior to or,
b.) subsequent to the medication of the patient pursuant to his/her PRN order. (D-*KAHN, KANTAR, MALAMUD, POMERANTZ, SEIGEL, SZLYK, TURNQUEST, GILL, GOLDBARG, CACCIOLA, SEIL*—1st set of admissions, No. 59.) (Plaintiffs' Exhibit 34.)
282.) A member of the nursing staff had and has the ultimate decision making power of whether or not a patient should receive or needs a give PRN medication (if there was a PRN order in a patient's record), whether the medication was to be administered voluntarily or involuntarily. (D-*GOLDBARG*, D-*OSBORNE*—1st set of admissions, No. 16.) (Plaintiffs' Exhibit 34.)
DR-282.) The question of "ultimate" authority is one of semantics. As Drs. Seil and Gill noted, because of their proximity and heightened awareness of a patient's needs, licensed nurses have the power to administer voluntary medications if there were a PRN order in a patient's records. Licensed nurses do not have the "ultimate" decision making power, because they can be overruled by a doctor. Licensed nurses do not have the power to administer involuntary medication pursuant to no more than a physician's PRN order. Gill and Seil - First set of Admissions, #16.
283.) Physician PRN orders have been used by the staff as a chemical restraint in circumstances in which the nursing staff determined its use was appropriate in a particular circumstance. (D-*SZLYK, GOLDBARG, CACCIOLA, OSBORNE*—1st set of admissions, No. 17.) (Plaintiffs' Exhibit 34.)
284.) If a patient is being upset by environmental factors, attempts to remove the patient from the environment should be considered; such as, separating the patient from another patient, specialing the patient or offering a quiet room. Only after these above measures have been considered and rejected, in an emergency should chemical restraint or seclusion be

used. (Statement of agreed fact for damages and injunctive relief, No. 2.) (Stip. p. 3.)

(XV.) *IT IS UNACCEPTABLE MEDICAL PRACTICE TO LEAVE TO THE DISCRETION OF THE NON-PHYSICIAN STAFF THE CIRCUMSTANCES IN WHICH ANTI-PSYCHOTIC MEDICATION CAN BE USED.*

285.) In December 1973 and January 1974, Betty Bybel was telling patients to refuse their medication and telling the patients that the staff was incompetent and full of baloney. Layne Erban, the nursing supervisor stated that Betty Bybel was a "ringleader" and that such behavior would not be tolerated and that one of the methods used to alter the behavior was to increase her medication. She was then over-sedated. (P-Cariello TR. 22-19, lines 23-25; 22-20; 22-21; 22-21; Doc. No. 300209.)

286.) In April 1974, Layne Erban told the staff that they would have to "snow" Betty Bybel with medication to keep her over-medicated so she wouldn't escape. She was then over-medicated and over-sedated. (P-Cariello TR. 22-16, lines 24-25; 22-17, 22-18, 22-19.)

287.) PRN medications are often used by staff members as a means to control unruly behavior, nuisance behavior, morally offensive behavior, bizzare behavior, because staff uses whatever means are made available to them to control patient behavior. This kind of means of controlling behavior has to be monitored and legally safeguard very carefully because it is a major intervention. (P-Messinger TR. 31-66.)

288.) The use of a PRN medication which is different than regular medication, accompanied by the word such as PRN agitation, X milligrams PO or X-25 milligrams IM would indicate that the PRN medication was being used as a chemical restraint rather than as part of a planned psychotherapeutic program. (P-Messinger TR. 31-64.)

289.) A use of a PRN medication which reads PRN agitation is written so as to leave the discretion the ward staff when that medication should be used. (P-Messinger TR. 31-64, 65.)

290.) It was not acceptable medical practice to have staff members using PRN orders when there is a PRN agitation order without involving the doctor who would make the decision as to when the medication should be used. (P-Messinger TR. 31-65.)

291.) The forcible use of medication is a drastic intervention into another person's life. It is often experienced as a violation of bodily integrity. It undermines other kinds of treatment possibilities, and therefore calls for a physician's attention to that decision. (P-Messinger TR. 31-65.)

292.) A PRN order in a physician's order book which indicates a certain kind of medication to be prescribed, the precise amounts to be used and the means by which they can be used is not sufficient control over its use to ensure the proper use of that medication. P-Messinger TR. 31-66.)

Other Proposed Findings

293.) The average patient census in the Austin Unit is anywhere between 65-75 patients. (*D-GILL* 63-104.)

294.) Approximately 3-5 percent of patients in the Austin Unit were actually engaged in violent behavior periodically. (D-*GILL* 63-107.)

295.) According to Dr. Gill, approximately 20-25 percent of the patients at the Austin Unit were potentially violent. (D-*GILL* 63-107.)

No Compelling State Interest

296.) Violent acts have been committed both by some patients who are not using and some patients who are accepting medication. (Statement of Agreed Facts #8, Stip., p. 352.)

297.) Patients who have refused as well as patients who have accepted their medication are and have been hostile, angry, and belligerent prior to and subsequent to the restraining order. (Statement of Agreed Facts for Injunctive Relief, #8.) (Stip., p. 352.)

298.) There are some patients in the Austin Unit whose mental condition has not improved during their hospitalization.

(Statement of Agreed Facts for Injunctive Relief, ¶19.) (Stip., p. 353.)

No Compelling State Interest—Lack of harm to Doctors

299.) Some patients are resistant to taking medication and doctors or staff will inform them that it is to their benefit to take it, and generally most patients will voluntarily agree to take the medication. (Statement of Agreed Facts for Injunctive Relief, ¶7.) (Stip., p. 352.)

300.) It is a reasonable and less drastic alternative to a patient who does not constitute an immediate danger to others, to have a petition for guardianship taken out to determine if the patient is competent to refuse, rather than forcibly medicating the patient. (D—Olin TR. 51-35.)

DR-300.) Dr. Olin testified that it is a reasonable alternative to seek a guardian rather than forcibly medicate a patient that Dr. Olin did not believe to be seriously ill. Dr. Olin did not state that such an alternative was less drastic, although the question postulated that possibility. Dr. Olin very specifically testified regarding the failings of the guardianship system when one needs to treat a severely ill, psychotic patient. Tr. 51 at 34-37, 19, 42 (Olin); Tr. 52 at 38-41 (Olin).

301.) A non-mental patient has the right to refuse treatment even though the inevitable consequence may be the patient's death. (D—Olin TR. 51-45; 51-46.)

302.) Generally, seclusion is a less drastic and less intensive alternative than forced medication. (P—Rundle Tr. 30-56, lines 9-20.)

DR-302.) Whether a patient should be forcibly medicated before being secluded in a physical emergency depends upon the circumstances. Tr. 52 at 67-69 (deMarneffe).

303.) Prior to the temporary restraining order, the Department of Mental Health regulations only authorized forcible medication to be used as a chemical restraint. (D—*SEIL* TR. 58-76; 58-77; 58-78.)

DR-303.) This finding is based upon a portion of Dr. Seil's

deposition which Dr. Seil notes in his testimony is confusing. Specifically, as Dr. Seil notes, it is not clear whether he testified at his deposition whether it was before or after the temporary restraining order that forcible medication could be used as a chemical restraint and to what extent the DMH regulations were the basis for this restriction. Regardless of Dr. Seil's testimony regarding DMH Regulations, the best evidence is the DMH regulations themselves which did not only authorize the use of forcible medication as a chemical restraint. See Defendants' Proposed Findings of Fact, J-116, 117.

304. With an incompetent patient, in a non-emergency situation there needs to be a review procedure outside the hospital setting to determine whether treatment should be forced. (P-Rundle TR. 30-75, lines 19-25; 30-76, line 1; 30-80, lines 13-25; 30-81, lines 1-15.)

DR—304.) Dr. Rundle specifically said that it is proper to forcibly medicate incompetent patients in non-emergencies if the decision has been reviewed by the senior psychiatrist in charge. Tr. 30 at 81-82 (Rundle)

2. Defendants' Proposed Findings of Fact and Plaintiffs' Rebuttal*

(III.) *FORCIBLE AND INVOLUNTARY MEDICATION*

A. *Forcible Medication - The Practice*

1. *The Practice - The Circumstances Under Which Patients Were Forcibly Medicated At the Austin and May Units*

J-86. Defendants only forcibly medicated patients in emergencies or psychiatric emergency situations. Specifically, defendants and supervisory nurses testified:

a. *Gill*

Before the temporary restraining order, it was more customary for staff to honor a patient's refusal than to forcibly or involuntarily medicate the patient. Tr. 66 at 66 (Gill). There were many such occurences. Tr. 64 at 48 (Gill).

Before the temporary restraining order, the Austin Unit would forcibly medicate patients in a psychiatric emergency, not waiting for a physical emergency. Tr. 65 at 101 (Gill).

The Austin Unit forcibly and involuntarily administered medication when they felt it was medically called for. They only believed it was medically called for in a psychiatric emergency. Tr. 68 at 113-114 (Gill).

Dr. Gill never observed a patient during his time at the Austin Unit being forcibly medicated in any situation in which the patient was not, at a minimum, acutely ill in a state of psychiatric emergency. Tr. 64 at 59 (Gill).

Forced medication was used to prevent potential violence. Patients in severe psychotic agitation were forcibly medicated to alleviate their psychotic pain when their conditions did not at that time pose a serious threat of violence. However, their agitation could possibly have

* Plaintiffs' Rebuttals are designated "PR"

escalated into violence if the patient were not forcibly medicated. Tr. 64 at 55 (Gill).

Patients in severe agitation of psychotic proportions were forcibly medicated as they were in a gret deal of pain, even though their condition did not pose a problem in terms of assaultiveness or self-descructive behavior. Tr. 64 at 54-55 (Gill).

PR—*Dr. Gill*

PR—1.) Dr. Gill admitted that he authorized and ordered the involuntary medication of patients in the Austin Unit regardless of whether or not it was a physical emergency or even a 'psychiatric emergency', as long as he believed the medication might help the patient, even though the patients refused their medication. (J-90; J-89; J-86A.) (D-*GILL* TR. 68-52; 68-53; 68-54, lines 1-10.)

PR—2.) Dr. Gill stated under oath in the affidavit he filed with this court in support of the defendants' motion to dissolve the temporary restraining order: "Before the issuance of the temporary restaining order, *medication was used involuntarily in non-emergencies* in accordance with D.M.H. Regulation 223.03 as part of a planned medical psychotherapeutic program." (Emphasis added.) (D-*GILL* TR. 11-148, lines 24-25; 11-149, lines 1-7.)

PR—3.) *This statement was authored by the defendant GILL, not the plaintiffs.* The defendant specifically used the word *non-emergency*. The words 'psychiatric emergency' did not appear in the affidavit.

PR—4.) The first time any of the defendants used the term 'psychiatric emergency' was at the trial. The term 'psychiatric emergency' did not appear in all the interrogatory answers, admission responses, or in any deposition answer which the plaintiffs or the defendants introduced at trial.

PR—5.) Dr. Gill's affidavit #3 was filed in order to convince the court to dissolve a court order. Either the defendant *GILL* was filing an inaccurate statement with the court when he

sought to dissolve the court's order or else patients were involuntarily medicated in non-emergencies. Based on Dr. Gill's *admission* late in his cross examination, that patients were medicated involuntarily regardless of whether there was a psychiatric emergency, the court should find that it was the policy of the Austin Unit to involuntarily medicate when there was neither a physical nor a so-called 'psychiatric emergency.' (J-89; J-90; J-86.)

b. *Seil*

Patients were not forcibly medicated at the May Unit in any situation other than when the patient was acutely ill and in a state of psychiatric emergency. Tr. 58 at 22 (Seil).

From January, 1974, through April 30, 1975, Dr. Seil never observed a patient being forcibly medicated in any situation in which the patient was not acutely ill and in a state of psychiatric emergency. Tr. 58 at 22 (Seil).

PR—*Dr. Seil*

PR—6.) Until Dr. Seil filed his affidavit with the court seeking to dissolve the temporary restraining order, Dr. Seil consistently maintained the position, both in his interrogatories and deposition, that medication was used involuntarily only as a restraint in the May Unit prior to the temporary restraining order being issued. In his affidavit, however, he specifically stated to the court that: "*Medication was used involuntarily in non-emergencies.*" (Emphasis added.) Dr. Seil also stated in his affidavit that, "It is standard psychiatric practice throughout the country *to use medication involuntarily in non-emergencies* on involuntarily committed patients when said medications are an integral part of a planned psychotherapeutic program." (Emphasis added.) In neither statement did Dr. Seil use the term 'psychiatric emergency.' In fact, in none of his answers or responses to interrogatories or admissions nor in his answers in depositions or in the affidavits

he filed with this court did Dr. Seil ever use the term 'psychiatric emergency.' This term was used by him for the first time at trial, claiming that all his previous statements under oath concerning medication practices were inaccurate. Based on all his responses, it is clear that in the May Unit prior to the temporary restraining order medication was used involuntarily in physical and 'psychiatric emergencies' and in non-emergency situations. (J-86B; J-89.) (D-*SEIL* TR. 58—61-83.)

c. *Kahn*

The policy at the May Unit was that a patient refusing medication, without certain special conditions, was not administered the medication. Tr. 62 at 19 (Kahn).

Patients at the May Unit were not involuntarily medicated in non-emergencies. Tr. 62 at 20, 27 (Kahn).

However, involuntary patients received psychopharmacologic agents forcibly against their will when the medication was used as a restraint of last resort to deal with a serious threat of or as a result of extreme violence, personal injury, or attempted suicide. Tr. 62 at 26 (Kahn).

Patients were forcily medicated when they were a risk to themselves or to other people. Tr. 62 at 27 (Kahn).

d. *Kantar*

Before the temporary restraining order patients were forcibly and involuntarily medicated only in emergencies. Tr. 11 at 142-144 (Kantar). The definition of emergency for involuntary and forcible medication was not limited to actual threats or actual acts of violence. Tr. 11 at 154-155 (Kantar).

The Austin Unit did not involuntarily or forcibly medicate the chronic patients who had settled at the Unit. Tr. 11 at 163 (Kantar).

Before the temporary restraining order, a patient would be forcibly or involuntarily medicated if necessary for the patient's well-being. Tr. 11 at 108, 121 (Kantar).

Before the temporary restraining order, a patient would not be involuntarily or forcibly medicated simply because the medication would probably make the patient better. The patient would be involuntarily or forcibly medicted if the patient's condition was a serious one and that there was a great deal of anguish and trauma or some physically deteriorating situation. Tr. 12 at 118, 119 (Kantar).

Dr. Kantar would honor a patient's refusal if reasonable. Tr. 12 at 122 (Kantar).

e. *Szlyk*

Dr. Szlyk would involuntarily medicate only in a psychiatric emergency. Tr. 42 at 110-111 (Szylk).

Dr. Szylk would honor a patient's request not to be medicated against their will in a non-emergency. Tr. 6 at 16 (Szlyk).

f. *Schildkrout*

The policy of the Austin Unit was to forcibly medicate if there was a psychiatric crisis or psychiatric emergency. Tr. 43 at 110-111 (Schildkrout).

Dr. Schildkrout honored a patient's refusal of medication unless there was an emergency. Tr. 43 at 108 (Schildkrout).

g. *Cacciola*

Dr. Cacciola authorized the intramuscular medication of a patient against that patients will only when that patient was out of control and his behavior was escalating to a point where he might hurt himself or others. Tr. 56 at 30 (Cacciola). Dr. Cacciola was never informed of a patient being given intramuscular medication against his will except in those circumstances. Tr. 56 at 31 (Cacciola).

h. *Mazmanian*

Patients were involuntarily medicated if there was some indication of a psychiatric emergency state which

would necessitate using the medication as something which would be in the patient's best interests. Tr. 49 at 29-30 (Mazmanian).

The need to forcibly medicate was assessed on a case-by-case basis. Tr. 49 at 26-27 (Mazmanian).

i. *Herschel*

Patients at the Austin Unit were not involuntarily medicated except in psychiatric emergencies. Tr. 40 at 102, 103 (Herschel).

At the Austin Unit p.r.n. medication as given to a patient after he or she refused an oral dose only when it was determined that due to the patient's mental status and deterioration no other intervention would help that person at that time. Tr. 39 at 67 (Herschel).

In other than these circumstances, the patient's refusal of oral p.r.n. medication was honored in an attempt to develop a trusting relationship between staff and patient. Tr. 39 at 66, 67 (Hershel).

j. *Crane*

Patients at the Austin Unit were allowed to refuse in non-emergencies antipsychotic medication prescribed for them. Tr. 40 at 116, 117 (Crane).

Until the issuance of the temporary restraining order, patients at the Austin Unit who were in an ongoing psychiatric emergency or who were violent or suicidal were not allowed to refuse regular antipsychotic medication prescribed for them. Tr. 41 at 2, 2 (Crane).

k. *Burke-Green*

Patients were only medicated in emergencies in terms of the patients needing treatment. Tr. 61 at 71 (Burke-Green).

J-87. A psychiatric emergency, for which a patient might have been forcibly medicated, is not necessarily a situation constituting a serious threat of personal injury or violence to the patient or to others. Tr. 51 at 29 (Olin); Tr. 66 at 25 (Gill); Tr. 11 at 154, 155 (Kantar).

J-88. Before the temporary restraining order, patients were forcibly medicated in situations which would not have justified the seclusion of that patient, as the situation did not constitute a serious threat of personal injury, extreme violence or attempted suicide. Tr. 64 at 54-55 (Gill); Tr. 65 at 96-97 (Gill); Tr. 11 at 154-155 (Kantar); Tr. 40 at 103 (Herschel); Tr. 58 at 43-44, 46, 54-55, 56 (Seil); Tr. 61 at 71-72 (Burke-Green).

J-89. The only evidence given by defendants that they forcibly medicated patients in non-emergencies is found in answers to certain interrogatories and requests for admissions. When answering the interrogatories and admissions, defendants were interpreting the word emergency in the strict sense to mean the kind of situation which would merit seclusion, i.e., a personal injury, threat of personal injury or threat or occurence of violence. As all psychiatric emergencies are not situations meriting the use of seclusion, at the time they answered the interrogatories and requests for admissions, defendants stated they had forcibly medicated patients in non-emergencies. Tr. 68 at 112-113 (Gill); Tr. 11 at 148-149 (Kantar). (See the second Set of Admissions, Answer to Request #1, Tr. 11 at 156-157, and Pl. Ex. 33, for an indication of the way defendants were defining emergency when they answered the Admissions and Interrogatories).

J-90. No defendant has ever testified that any patient was forcibly medicated in a situation that did not constitute a psychiatric emergency.

J-91. Plaintiffs have offered no evidence of a patient being forcibly medicated in a non-emergency in which plaintiffs have provided evidence of the time, place, date and people allegedly involved in the forcible medication.

J-92. Plaintiffs have offered no evidence of a patient being forcibly medicated in a non-emergency in which they have in any way directly tied the forcible medication to one of the defendants in this case.

a. Boston State Hospital mental health workers were under a contractual obligation to report alleged abuses at the hospital to their superiors or face disciplinary acts. Tr. 39 at 78, 79 (Herschel).

b. Staff members at the Austin Unit had the means available to report grievances and alleged abuses by the form 5 or by speaking directly to their supervisors. Tr. 39 at 78 (Herschel).

c. There were regular procedures for staff members to report to the inpatient director abuses in the use of medication. Tr. 64 at 60-61 (Gill).

d. During the entire period of his employment at the Austin Unit, Dr. Gill never received any staff complaints regarding the forcible medication of patients. Tr. 64 at 58-59 (Gill).

e. No staff members ever reported to Dr. Kahn any abuses regarding forced medication at the May Unit when he was inpatient director. Tr. 60-79 (Kahn).

f. From January, 1974, through April, 1975, Dr. Seil never received any complaints that patients were being forcibly medicated and the patient was not acutely ill and in a state of psychiatric emergency. Tr. 58 at 22, 23 (Seil).

g. Staff members at the May Unit had the means available to report grievances and alleged abuses by the Form 5 or by speaking directly to Dr. Siegel, Tr. 49 at 57-58 (Siegel); Dr. Kahn, Tr. 60 at 78-79 (Kahn).

2. *The Practice - Factors Influencing the Decision Whether to Forcibly Medicate A Patient At the Austin and May Units*

J-93. It was Austin Unit policy not to medicate forcibly or involuntarily if the medication was not absolutely necessary to the proper treatment of the patient. Tr. 6 at 20-23 (Szlyk).

J-94. In deciding whether to forcibly or involuntarily medicate a patient, it was Austin Unit policy to take into account whether the failure of the patient to take medication

would prolong that patient's hospitalization. Tr. 64 at 50-52 (Gill).

J-95. In deciding whether to forcibly or involuntarily medicate a patient it was Austin Unit policy to take into account whether or not the doctor believed that the reason given for refusal by the patient was a rational reason. Tr. 64 at 52-54 (Gill); Tr. 11 at 145 (Kantar).

J-96. If a patient at the May Unit refused medication, the staff attempted to engage the patient in that form of treatment without forcing medication. Only after the patient refused medication over a considerable length of time and the treatment team involved had had numerous discussions regarding the patient's treatment, would the team evaluate the situation and make a judgment that the patient's condition was deteriorating and he or she required forcible medication. Tr. 61 at 52-54, 71 (Burke-Green).

3.) *Psychiatric Emergency Defined*

J-97. Psychiatric emergency is an acute psychotic process or very severe depressive process with the consequence that if left unattended, the condition will worsen. Tr. 58 at 65, 66 (Seil).

J-98. The acute patient out of touch with reality, is in a state of a psychiatric emergency. Tr. 51 at 100 (Olin).

J-99. A psychiatric emergency is a paralysis in the sphere of reality orientation. Tr. 60 at 87 (Frazier, "Comprehensive Management of Psychiatric Emergencies," vol. 9, *Psychosomatics*, p.7).

J-100. A psychiatric emergency is any urgent psychiatric condition, functional or organic, for which immediate treatment would increae or contribute to the patient's likelihood of recovery, or provide urgently needed protection. Tr. 60 at 88 (Frazier, ibid.)

J-101. Only a few kinds of behavior seem to be consistently accepted as constituting or implying a psychiatric emergency, namely, suicidal behavior, whether seriously meant or a gesture, assaultiveness, property destruction, extreme anxiety, panic and bizarre behavior. Tr. 60 at 89 (Frazier, ibid. at p.9)

J-102. The patient who because of his mental illness — whether he be, for example, acutely Manic, a chronic manic-depressive, or schizophrenic — does not take antipsychotic medication, does not eat or drink or take other necessary medication such as insulin, constitutes an emergency. Tr. 60 at 91, 92 (Kahn).

J-103. The acutely psychotic patient may or may not express their rage or terror through some violent activity. Tr. 66 at 20 (Gill).

J-104. A patient who is psychotic and cannot make rational decisions, although not violent but simply says he is very depressed, apathetic, sits in a corner, and refuses medication, is in a psychiatric emergency state. Tr. 51 at 31, 32, 36 (Olin).

J-105. The initial part of a behavioral pattern that starts off and eventually escalates into dangerous behavior is a psychiatric emergency. Tr. 51 at 29-30 (Olin).

J-106. There are patients who may be in a constant state of psychiatric emergency from the time they enter the hospital until it is almost time for them to leave. Tr. 40 at 102, 103, 112, 113 (Herschel); Tr. 41 at 3 (Crane).

J-107. Psychiatric emergencies may be ongoing and lengthy, lasting on a daily basis for a period of months. Tr. 39 at 69 (Herschel).

PR—3. *Psychiatric Emergency Defined*

PR-7.) Even the defendants and their witnesses substantially disagree on the definition of 'psychiatric emergency.' If the court were to combine all these definitions of 'psychiatric emergency', the court would have to find that all persons diagnosed as mentally ill who are inside or outside a mental hospital could be involuntarily or forcibly medicated, including persons not even diagnosed as mentally ill. (See for example J-101, "exhibiting bizarre behavior is a psychiatric emergency" J-97 — J-105.)

B. *Acceptability of Forcibly Medicating Patients in Psychiatric Emergencies, and Even in Non-Emergencies*

J-108. It is standard psychiatric practice to forcibly medicate patients in need of the medication. Tr. 66 at 49 (Gill).

J-109. Doctors have the obligation to relieve the suffering that a psychiatric patient is experiencing because of his illness. Tr. 51 at 110 (Olin).

J-110. It was acceptable medical practice to authorize the involuntary or forcible medication of patients in non-emergencies under certain conditions. Tr. 57 at 106-107 (Brill).

J-111. It was acceptable medical practice from January 1, 1973, through April, 1975, to involuntarily or forcibly medicate a patient suffering from severe anxiety of psychotic proportions. Tr. 57 at 102-103 (Brill).

J-112. It is proper to forcibly medicate incompetent patients in non-emergencies if the decision has been reviewed by the senior psychiatrist in charge. Tr. 30 at 81-82 (Rundle).

J-113. Incompetent patients should be forcibly medicated when the doctor believes it is best for the patient. Tr. 30 at 51 (Rundle).

J-114. It was acceptable medical practice from 1973 through April, 1975, to administer forcible medication to a psychiatric patient at an earlier stage in a psychiatric emergency than intervention with seclusion should take place. Tr. 51 at 34-35 (Olin).

J-115. During the early 1970's, until the issuance of the temporary restraining order in this action, it was standard procedure to involuntarily medicate a patient in a state hospital who was refusing antipsychotic medication. Physicians at that time had been trained that the maintenance dosage of the medication that a patient was receiving was important and that if a person received a diagnosis of some psychotic process

and the medication needs were determined, that it was important at all costs to try to continue that medication, even if at moments in time the patient resisted. Tr. 63 at 69, 70 (Myerson).

It was considered acceptable medical practice prior to the temporary restraining order in this case to give medication to somebody who the physicians felt needed it even if the person resisted the medication; it was felt that the situation was analogous to somebody who had an infectious disease, like pneumonia, who needed penicillin every four hours. Tr. 63 at 70, 71 (Myerson).

J-116. Section 220.02 of the Department of Mental Health regulations in effect now and during the time covered by this law suit provides that upon admission to a facility for care and treatment, a person shall receive treatment and rehabilitation in accordance with accepted therapeutic practice, including intramuscular medication when appropriate. Stips. II, Damages and Injunctive Relief, 16b.

J-117. Pursuant to Section 223.03 of the Department of Mental Health regulations in effect now and during the time covered by this law suit, medication administered as part of a planned medical, psychotherapeutic program was not a restraint whose use would be limited to emergency situations such as a serious threat of extreme violence, personal injury or attempted suicide. Stips. II, Damages and Injunctive Relief, 16e.

J-118. It was acceptable medical practice from January, 1973, through April, 1975 to forcibly medicate, without getting a guardian, an involuntary patient in circumstances which were not life threatening but where the medication was necessary for the well-being of the patient. Tr. 52 at 54-55 (deMarneffe); Tr. 51 at 45 (Olin).

J-119. At McLean Hospital from January, 1973, through April, 1975, involuntary patients were forcibly medicated without getting a guardian in circumstances which were not

life threatening but where the medication was necessary for the well-being of the patient. Tr. 52 at 57 (deMarneffe).

J-120. It was acceptable medical practice from January 1973, through April, 1975, to involuntarily or forcibly medicate a voluntary patient without getting a guardian, when the patient had signed a consent form agreeing to the use of intramuscular medications as therapy, in circumstances which were not life-threatening but where the medication was necessary for the well-being of the patient. Tr. 51 at 43 (Olin); Tr. 52 at 61 (deMarneffe).

J-121. It was acceptable medical practice from January, 1973, through April, 1975, to involuntarily or forcibly medicate a voluntary patient even though the doctor believed the patient to be committable. Whether the doctor believes the patient is committable is irrelevant, because, unless the patient were to give written notice that he or she wishes to leave the hospital, the patient could not be involuntarily committed. Tr. 51 at 46 (Olin).

J-122. It is acceptable medical practice to forcibly medicate a voluntary patient in a non-emergency when medically indicated. Tr. 57 at 128-129 (Brill).

J-123. Any comprehensive treatment plan to be effective requires a degree of cooperation by the patient; some procedures incidental to the plan require more cooperation than others; it is possible, for example, to give patients electroshock and medication without their cooperation, and this may be done in an effort to make the patient more cooperative and receptive to other treatment procedures. Tr. 60 at 138 (American Psychiatric Association, Position Statement on the Adequacy of Treatment, *Amer. J. Psychiat.*, May, 1967, at p. 1459).

J-124. The utilization of involuntary restraint may be viewed in one sense as analogous to problems encountered in child rearing wherein there are no sharp delineations as between guidance and discipline or between discipline and punishment, all of which are directed towards putting internal

and external limitations on unacceptable behavior. Restraints may be imposed from within by reinforcing a patient's inner defenses, or from without by pharmacologic means or by locking the door of a ward. Either imposition may be a legitimate component of a treatment program. Only if a patient were restrained and did not receive any of the treatments cited above could the restraint properly be called punishment. Further, it is unsound to dismiss a procedure as "purely custodial" or "purely punishing" without assessing the total circumstances in which it has been prescribed. The procedure is often of therapeutic value. Tr. 60 at 138, 139 (American Psychiatric Association, Position Statement on the Adequacy of Treatment, *Amer. J. Psychiat.*, May, 1967, at p. 1459).

J-125. If a patient is acutely psychotic and has tardive dyskinesia, neuroleptic drug therapy should be instituted without written consent, because it is an emergency. (Sovner, DiMascio, Berkowitz, and Randolph, "Tardive Dyskinesia and Informed Consent, Psychosomatics, March 19, 1978, vol. 19, no. 3, p. 173).

PR—*ACCEPTABILITY OF FORCIBLY MEDICATING PATIENTS IN PSYCHIATRIC EMERGENCIES, AND EVEN IN NON-EMERGENCIES*

PR—8.) Dr. Rundle did not state it was proper to forcibly medicate incompetent patients in non-emergencies if the senior psychiatrist(s) in charge reviewed the decision. His answer was based on a hypothetical that there was no other review procedure outside the hospital (such as a court or a guardian). (J-112.) (P-Rundle TR. 30-80; 30-81.)

PR—9.) Dr. Rundle's testimony was taken out of context. His testimony was based on the assumption that Willie Wadsworth was acting dangerously on December 25, 1974. In that circumstance, according to Dr. Rundle, it would be acceptable to have forcibly medicated him on that day. (J-113.) (P-Rundle TR. 30-50; 30-51.)

C. *Involuntary Medication - The Practice*

J-126. At times when a patient was in an acute psychiatric emergency, he or she was told by nurses that he or she would receive intramuscular medication if they did not take their regular medication orally. Tr. 39 at 69 (Herschel).

J-127. It was the policy of the Austin Unit only to involuntarily medicate during emergencies. Tr. 42 at 95 (Press).

J-128. Dr. Gill never observed nurses or residents threatening patients with intramuscular medication during his entire time at the Austin Unit if they refused to take their oral medication in any situation in which the patient was not acutely ill in a state of a psychiatric emergency. Tr. 64 at 59 (Gill).

J-129. During his entire time at the Austin Unit, Dr. Gill never received any complaints that patients were being threatened with intramuscular medication if they refused to take their medication when the patient was not acutely ill in a state of psychiatric emergency. Tr. 64 at 60 (Gill).

J-130. Nurses or doctors at the May Unit threatened patients with intramuscular medication if they refused to take their oral medication only in situations in which the patient was acutely ill and in a state of psychiatric emergency. Tr. 58 at 22 (Seil).

J-131. It was not the policy at the May Unit between January 1, 1973, and April 25, 1975, to inform a patient that if he or she did not take medication orally, he or she would be given the medication intramuscularly. Tr. 61 at 54 (Burke-Green).

J-132. From January, 1974, through April 30, 1975, Dr. Seil never observed nurses or doctors threatening patients with intramuscular medication if they refused to take their oral medication in any situation in which the patient was not acutely ill and in a state of psychiatric emergency. Tr. 58 at 22 (Seil).

J-133. From January, 1974, through, April 30, 1975, Dr.

Seil never received any complaints that patients were being threatened with intramuscular medication if they refused to take their oral medication when the patient was not acutely ill and in a state of psychiatric emergency. Tr. 58 at 22 (Seil).

J-134. It was never the policy or practice at the May Unit to seclude patients simply because they refused medication. Tr. 60 at 78 (Kahn); Tr. 61 at 54 (Burke-Green).

J-135. During his entire time of employment at the Austin Unit Dr. Gill never observed or received complaints that patients were threatened with seclusion if they refused to take their medications. Tr. 64 at 60 (Gill).

D. *Acceptability of Involuntarily Medicating Patients*

J-136. It was acceptable medical practice from January, 1973, through April, 1975, for a nurse to inform a patient on an acute psychiatric ward that if he or she did not take his or her medication voluntarily, he or she would be given it intramuscularly. Tr. 57 at 104-105 (Brill); Tr. 52 at 71 (deMarneffe).

J-137. It is the humane thing to do to give a patient a Hobson's choice regarding his medication and not to wait until the patient's condition has escalated to such a point that there is an extreme emergency before giving the medication. Tr. 52 at 71 (deMarneffe).

J-138. It was acceptable medical practice from January, 1973, through April, 1975, to authorize nurses to medicate patients intramuscularly when in the discretion of the nurse the patient was out of control. Tr. 52 at 70 (deMarneffe).

J-139. It was acceptable medical practice from January, 1973, through April, 1975, to write a P.O. or IM PRN medication order for an antipsychotic drug. Tr. 52 at 70 (deMarneffe).

E. *Reasons For Forcibly and Involuntarily Medicating Patients - The Involuntary Patient Specifically*

J-140. Involuntary patients are sent to mental hospitals with the intent they be treated. Tr. 52 at 104 (Bergstresser).

J-141. In Massachusetts, the commitment certificates authorize treatment of a patient. Tr. 36 at 40-41 (Whitaker).

J-142. For involuntary patients, a decision has already been made by the court that the patient has been admitted to the hospital for care and treatment. Tr. 52 at 54 (deMarneffe); Tr. 51 at 105 (Olin).

J-143. All voluntary patients by definition under law have been committed because of the likelihood of serious harm if they are not treated. M.G.L. c. 123, §1.

J-144. Involuntary patients are by definition a danger to themselves or other when not treated. M.G.L. c. 123, §1; Tr. 51 at 107 (Olin).

J-145. The commitment of a patient to a psychiatric hospital brings with it an obligation on the doctor to treat that patient involuntarily, if necessary. Tr. 11 at 128 (Kantar); Tr. 52 at 41 (Olin).

J-146. Defendants had the authority to treat involuntarily all involuntary patients, although they chose not always to do so. Tr. 11 at 157-158 (Kantar).

PR— E. *REASONS FOR FORCIBLY OR INVOLUNTARILY MEDICATING PATIENTS - THE INVOLUNTARY PATIENT SPECIFICALLY.*

PR—10.) Mr. Bergstresser stated in the following interchange with the judge:

THE COURT: Let me ask you this: Is there an issue that an involuntary commitment is for treatment? Otherwise it would be just incarceration. You'd have imprisonment without a trial. Can there be any question it has to be for treatment?

MR. BERGSTRESSER: Your Honor, I would think there is no question that the patient is sent there with the intent that he is there for treatment but that does not necessarily go hand in hand with the Court saying that you can engage in any treatment without the assent or over the objection of the patient, if the patient is competent.

(J-140.) (TR. 52-104, lines 17-25; 52-105, lines 1-3.)

PR-11.) Voluntary patients are not committed. Involuntary patients are committed under the law because of the likelihood of serious harm *if discharged*. The statutory section which involves commitment does not mention treatment. (J-143.) (M.G.L. Ch. 123 Sec. 1, 7, 8.)

PR-12.) As a result of being committed, an involuntary patient is guaranteed that treatment will be made available. Massachusetts law does not mandate that treatment be coerced, if refused. (J-142; J-145.) (M.G.L. Ch. 123.)

PR-13.) Involuntary patients are by definition a danger to themselves or others if discharged into the community. (J-144.) (M.G.L. Ch. 123 Sec. 1, 7, 8.)

(G.) *Reasons For Forcibly and Involuntarily Medicating Both Involuntary and Voluntary Patients*

(1.) Allowing Patients to Refuse Antipsychotic Medication Will Necessarily Curtail the Benefits of These Medications

(a.) *General Use and Effectiveness of Antipsychotic Medication*

J-152. For major mental illness, psychotropic drugs are a central component of a treatment program and are so considered by psychiatric programs around the world. Tr. 57 at 31 (Brill).

J-153. Psychopharmacotherapy must be considered an essential component of a treatment program for over 50 percent of the mental patients hospitalized for over two years. Tr. 57 at 32-33 (Brill).

J-154. It is necessary for proper treatment to administer psychotropic medication to the vast majority of seriously disturbed patients and the vast majority of acute mental patients. Tr. 57 at 36-38 (Brill).

J-155. For patients who have been in the hospital for a few years, the introduction of antipsychotic medication has made a spectacular difference in their recovery rate. Tr. 57 at 33-34 (Brill).

J-156. In mental hospitals, anywhere from 75 to 85 percent of the patients at any one time are on a psychotropic drug. Tr. 29 at 48 (DiMascio).

J-157. Dr. Brill, personally familiar with the operation of over 100 psychiatric hospitals in this country, Asia, North Africa, South America and Europe, knows of no major hospital in the world that attempts to treat major psychiatric illness without psychotropic drugs. Tr. 57 at 30-31 (Brill).

J-158. Antipsychotic drugs have long-term effectiveness. Tr. 35 at 98 (DiMascio).

J-159. Anitpsychotic drugs are established and nonexperimental drugs. Tr. 57 at 34-35 (Brill).

J-160. The dangers that arise from anitpsychotic medication properly given are far less than the dangers of psychosis uncontrolled. Tr. 57 at 35 (Brill); Tr. 61 at 35 (Brill).

J-161. After reading thousands of articles, Dr. Brill has concluded there are no articles which show there is not a general consensus as to the relative safety and effectiveness of antipsychotic medications. Tr. 61 at 36 (Brill).

J-162. After reading thousands of articles, Dr. Brill is not aware of any well-designed study that conluded that antipsychotic drugs are not relatively effective and safe. Tr. 61 at 36 (Brill).

J-163. Dr. Brill is not aware of any leading clinical psychiatrist who believes that antipsychotic drugs are not relatively effective and safe. Tr. 61 at 36-37 (Brill).

J-164. Every drug, before it goes on the market, needs the approval of the FDA, both regarding its effectiveness and safety. The anitpsychotic medications on the market today have such FDA approval. Tr. 61 at 35 (Brill).

J-165. There is a sub-specialty of psychiatrists who treat their patients exclusively with drugs. Tr. 33 at 134 (Whitaker); Tr. 34 at 2-3 (Whitaker).

J-166. Thirty to fifty percent of the patient population at state hospitals are schizophrenics. Tr. 57 at 31-32 (Brill).

J-167. Pharmacotherapy is now established as a necessary, if not always sufficient, component of any comprehensive treatment program for schizophrenia. Tr. 35 at 105. (Klerman, "Pharmacotherapy of Schizophrenia," *Annual Review of Medicine*, Volume 25, 1974, p. 199).

J-168. Psychotropic medication is a central component for most patients with schizophrenia. Tr. 57 at 32 (Brill).

J-169. For hospitalized schizophrenics, pharmacotherapy is usually the most effective means of cutting short the patient's stay in the hospital and preventing future readmission. It would be practically impossible to have an effective treatment program for schizophrenic patients in a hospital setting without any reliance on antipsychotic medication at all. Tr. 35 at 111-114, 116-117 (DiMascio).

J-170. Pharmacotherapy with neuroleptic drugs is considered by most clinicians to be the treatment of choice for schizophrenic patients. Tr. 35 at 115 (DiMascio).

J-171. Without psychotropic medication, schizophrenic patients have a high probability of chronicity developing. Tr. 57 at 34 (Brill).

J-172. From a public health point of view, the only useful single therpeutic intervention is antipsychotic medication, which is both the cheapest and most effective treatment of schizophrenic symptomology. Tr. 35 at 109 (Shader, *Manual of Psychiatric Therapeutics*, [1975] p.95).

J-173. For the treatment of the chronic schizophrenic, the use of the anitpsychotic medications are the most effective means of treatment. Tr. 29 at 48 (DiMascio).

J-174. The efficacy of the antipsychotic drugs in the treatment of schizophrenia has been demonstrated beyond question. Phenothiazines and other antipsychotic drugs favorably modify the pathognomonic symptons of schizophrenia, that is, thought disorder, blunted affect withdrawal and retardation; and autistic behavior and mannerisms. Favorable changes in belligerence, restiveness, perceptual disturbances and

paranoid projection also occur with the use of antipsychotic drugs. Tr. 60 at 145 (Goodman & Gilman, *The Pharmacological Basis of Therapeutics*, 5th ed., [1975] at p.172).

J-175. For many understandable and good reasons, psychopharmacology is now preeminent in the treatment of schizophrenic patients. Drug administration reduces psychotic symptoms, dulls the pain of anguished patients, renders hospitalized patients dischargeable and maintains patients in the community. It provides a rational and effective mode by which the physician can induce desired changes in his patient well within the context of the medical model.

Pharmacological treatment of schizophrenia is extraordinarily important in psychiatry. Tr. 60 at 136 (Carpenter, McGlashon and Strauss, "The Treatment of Acute Schizophrenia Without Drugs: An Investigation of Some Current Assumptions," *Amer. J. of Psychiat.*, 1977, at p.14.

J-176. Pharmacological therapy is usually the most effective means of cutting short the patient's stay in the hospital and preventing future readmission. Tr. 60 at 141 (Lehman, "Pharmacological Treatment of Schizophrenia Bulletin, Summer, 1975, at p.28).

J-177. The efficacy of neuroleptic agents (antipsychotic drugs, major tranquilizers) in treating acute and chronic schizophrenia patients has been established by a vast number of adequately designed and controlled studies conducted over the past 20 years. These studies demonstrate the usefulness of neuroleptics in reducing disordered thinking, anxiety, delusions, hallucinations, social withdrawal, and other symptoms associated with schizophrenia. Tr. 35 at 108-109 (Shader, *Manual of Psychiatric Therapeutics*, [1975] p.84).

J-178. There are hundreds of controlled studies showing the effectiveness of antipsychotic drugs on acute schizophrenic patients and many controlled studies showing their effectiveness in treating chronic schizophrenic patients. Tr. 35 at 120 (DiMascio).

J-179. 101 of 127 double-blind placebo-controlled studies concluded that phenothiazines are superior to placebo for treatment of the acute schizophrenic syndrome. In the remaining 26 the effects of the drugs were shown to be equal to placebo, but in many of these reports the dosages of the phenothiazines were homeopathic (i.e., doses too low to have any clinical effect). Well-designed studies also have demonstrated that the butyrophenones, thioxanthenes and the new phenothiazines are effective antipsychotic agents. When compared to other treatment modalities, such as psychotherapy and inpatient hospital milieu therapy, drug therapy is the most effective in the treatment of the acute schizophrenic episode. Tr. 60 at 142, 143 (Barsuck and Schoonover, *The Practitioner's Guide to Psychoactive Drugs*, at p.79-80).

PR-a. *General Use and Effectiveness of Antipsychotic Medication*

PR-16.) Even according to Dr. DiMascio, the chief pharmacologist of the Massachusetts Department of Mental Health, psychopharmacological agents are an essential component of a treatment program for only some acute schizophrenic patients. (J-154; J-168; J-167; J-170.) (P-DiMascio TR. 29-7; 29-49, lines 19-25.)

PR-17.) However, Dr. Brill admitted that Dr. William Crane is a leading and respected clinical psychiatrist, and a member of the Food and Drug Administration College of Neuropsychopharmacology, and the American College of Neuropsychopharmacology. Dr. Crane has stated that "the amount of medication usually prescribed for schizophrenia and other psychoses is unsafe and often unnecessary." He also stated that "the late neurologic effects of neuroleptics were unexpected, and their seriousness is being recognized now. The fact that a high proportion of patients are now affected by permanent neurologic effects is sufficient evidence that the current practices of drug therapy are unsafe." (J-163.) (D-Brill

TR. 57-135, lines 4-12; 61-18, lines 8-15. P"Crane Risks" TR. 61-20, lines 1-5; see also TR. 61-22, 61-23. See also P—"Crane - Two Decades" TR. 57-135, lines 13-20.)

PR-18.) There is substantial evidence that the plaintiffs Hunt, Bybel, Warner, Wadsworth, Colleran and Rogers "calmly refused their medication", and then were forcibly or involuntarily medicated, even though Dr. Gill admits in such a circumstance a patient would be neither in a physical nor a psychiatric emergency. (J-290.) (D-*GILL* TR. 66-61; 66-62. See Proposed Findings of named plaintiffs.)

(b.) *Specific Beneficial Actions of Antipsychotic Medications*

J-180. Of all the treatments that have come forth so far through the history of psychiatry, antipsychotic medication seems to be the most specific. Tr. 66 at 12 (Gill).

J-181. Antipsychotic drugs not only calm patients, but they interrupt and reduce psychotic thinking. Tr. 66 at 14 (Gill); Tr. 35 at 85, 123-125 (DiMascio).

J-182. Anitpsychotic medication controls psychosis. Tr. 57 at 26 (Brill).

J-183. Antipsychotic medication acts on different parts of the brain, some which deal with stimulation, some which deal with tranquilization, and some which deal with psychotic thinking. Tr. 57 at 18-19, 23 (Brill).

J-184. Antipsychotic drugs affect the biochemistry of the psychotic disorder so that the ordinary psyche can flourish again and start to grow. Tr. 66 at 17 (Gill).

J-185. When a person is psychotic, antipsychotic drugs often cause a spectacular improvement in the person's ability to think. Tr. 57 at 54 (Brill).

J-186. Anitpsychotic drugs cause perception and cognition of psychotic patients to improve. Tr. 57 at 55-56 (Brill).

J-187. While the sedative effects of very high doses of antipsychotic drugs may lead to slowing of though processes, clouded consciousness and impairment in reasoning, these ef-

fects are vastly outweighed by the improvements the drugs bring for the psychotic patient. Even on high dosages, a patients reasoning and thought processes regularly improve. Tr. 57 at 56-57 (Brill). Moreover, in some patients in whom their thought processes are so rapid that they cannot act consistently with these thought processes, slowing thought processes may be an appropriate treatment. Tr. 35 at 117 (DiMascio).

J-188. Neuroleptic drugs specifically diminish the thought disorder, the hallmark of schizophrenia. The more florid the patient's psychotic symptomatology, the more likely he is to respond. These drugs have the greater effect on hallucinations, delusions, combativeness, tension, restlessness, and social withdrawal. Tr. 57 at 6 (Brill).

J-189. The vast preponderance of medical literature shows a relationship between the use of anitpsychotic medication and a reduction in schizophrenic thinking. Tr. 57 at 27, 28 (Brill).

J-190. There are a large number of studies showing that antipsychotic medications cause improvement of a patient's mental illness. Tr. 57 at 28 (Brill).

J-191. Antipsychotic medication influences the psychosis directly and not at all through a general blanket of sedation. In fact, sedation eventually disappears completely. Sedation is a side effect of the medication and not the primary effect. Tr. 57 at 15 (Brill).

J-192. Phenothiazine drugs have a generalized anti-schizophrenic effect and are useful in patients suffering from acute schizophrenic psychosis, irrespective of whether or not overactivity and excitement are the major components of the clinical picture. Tr. 35 at 81-82 (Dimascio), (NIMH, Collective Study Group, "Phenothiazine: Acute Schizophrenia Effectiveness", [1964] p. 51); Tr. 57 at 15-16 (Brill).

J-192A. Withdrawn, apathetic patients tend to become more active and less apathetic when placed on phenothiazine therapy, while overactive patients tend to become less so. Tr.

35 at 98-99 (Klein & Davis, *Diagnosis & Drug Treatment of Psychiatric Disorders*, [1969] pp.83-84).

J-193. Tranquilizer is a misnomer for antipsychotic medication because it implies clinical utility only in those patients who are excited and, therefore, require a calming effect. Clinical and research experience has demonstrated that current drugs also have significant effects on disturbed thinking, such as occurs in schizophrenia, and that they are unlikely to significantly influence excitation, overactivity, or agitaton, which does not occur in the presence of disturbed thinking. Tr. 35 at 107-108 (Herman, "Pharmacotherapy of Schizophrenia", Ann. Rev. of Medicine, Vol. 25, 1974, p.213).

J-194. States of psychotic behavior which are not associated with demonstrable delusions or hallucinations, such as panic states and rage states, respond to the use of antipsychotic medication. Tr. 57 at 8 (Brill).

J-195. Antipsychotic drugs provide significant benefits in the following areas: Social participation, confusion, self-care, hebephrenic, agitation and tension, slowed speech, incoherent speech, irritability, indifference to environment, hostility, auditory hallucinations, ideas of persecution, disorientation. Tr. 35 at 79-81 (DiMascio) (NIMH, Psychopharmacology Service Center, Collective Study Group, "Phenothiazine: Acute Schizophrenia Effectiveness", [1964] p.254).

J-196. While when given to a normal individual, antipsychotic medication in full doses has a sedative effect, at least for a period of time, where one is treating a psychotic individual who is already disturbed in his functioning, the normal effect of antipsychotic medication is to improve the level of functioning. Tr. 57 at 53 (Brill).

J-197. While in a normal individual the sedative effects of antipsychotic medication have an interfering effect on learning, when the starting state is psychosis, learning improves sharply with the administration of antipsychotic drugs. Tr. 57 at 55 (Brill).

J-198. There are a number of studies which have concluded that learning is not impaired but in fact is improved by the administration of antipsychotic drugs. Tr. 35 at 77 (DiMascio).

J-199. Phenothiazines reduce errors of excessive breadth of concepts and improve a patient's ability to handle abstractions. Tr. 35 at 77-79 (DiMascio) (Klein & Davis, *Diagnosis & Drug Treatment of Psychiatric Disorders*, [1969] p.89).

J-200. The ability to remember responses improves for patients on antipsychotic drugs. Tr. 35 at 82-83 (DiMascio) (Klein & Davis, *Diagnosis & Drug Treatment of Psychiatric Disorders*, [1969] p. 89.)

J-201. Antipsychotic medications reduce psychotic initiative, such as aggression against others, disturbed behavior, running, screaming and shouting, but increase normal initiative. Tr. 57 at 61-62 (Brill).

J-202. Acuity improves in a psychotic individual who is distracted and confused by his illness and who is relieved by antipsychotic medication. Tr. 57 at 54 (Brill).

J-203. While antipsychotic medications reduce psychotic drive, they increase normal drive. Tr. 57 at 65-66 (Brill). In a psychotic individual, antipsychotic medication causes the individual to generate normal thoughts, not psychotic thoughts. Tr. 57 at 58 (Brill).

J-204. One of the major useful pharmacological properties of psychotropic agents is the capacity to alter emotional or mood states in certain "clinically desirable" directions; i.e., to reduce anxiety and fear, diminish hostile-aggressive expressions, relieve depressive-guilt feelings, or attentuate euphoriant manic affect. Tr. 36 at 77-78 (DiMascio, Giller and Shader, "Behavioral Toxicity of Psychotic Drugs", 32 *Connecticut Medicine* [Oct. 1968], p.772); Tr. 57 at 7-8 (Brill re. drugs reducing hostility & psychotic anxiety).

J-205. The use of antipsychotic drugs increases socializa-

tion. Tr. 57 at 59-60 (Brill). Antipsychotic medication increases the ability to relate spontaneously to others when the starting state is a psychosis. Tr. 57 at 60 (Brill).

J-206. Antipsychotic medication improves normal spontaneity. Tr. 57 at 62 (Brill).

J-207. Antipsychotic medications increase normal motivation of a patient. Tr. 57 at 62-63 (Brill).

J-208. The normal effect of antipsychotic medication is to reduce dependency. Tr. 57 at 61 (Brill).

J-209. When the starting state is a psychosis, antipsychotic drugs improve a patient's ability to experience pleasure. Tr. 57 at 59 (Brill).

J-210. In a psychotic individual, antipsychotic medication improves attention to detail spectacularly. Tr. 57 at 74 (Brill).

J-211. Antipsychotic drugs do not lessen assertiveness and make people conform. Tr. 14 at 37 (Kantar).

(c.) *Effects of Withdrawing Antipsychotic Medication from Patients Previously on the Medication*

J-212. Many patients, who were benefitting from antipsychotic medications, become acutely disturbed when their medication is withdrawn. Tr. 57 at 53 (Brill).

J-213. There is overwhelming evidence to conclude that maintenance antipsychotic drugs prevent relapse of chronic schizophrenic patients. There are 25 controlled studies, essentially all which find that any antipsychotic drug prevents relapse. All 25 of the studies indicate that more patients relapse on placebo than on drugs. Furthermore, the difference is quantitatively substantial. It is unusual to find such agreement among studies in psychiatry. The probability that these results would be achieved by chance alone is less than (10-87). Tr. 64 at 70-78 (Gill) (Davis, J. "Maintenance Antipsychotic Drugs Do Prevent Relapse: A Reply to Tobias & McDonald", Vol. 83, No. 3, *Psychol. Bull.* (1976), p.431, 432); Tr. 35 at 109-111 (Gardos & Cole, "Maintenance Antipsychotic Therapy: For Whom and How Long", in Lipton, DiMascio &

Killam (eds.), *Psychopharmacology, A Generation of Progress*, pp.1169-1170).

J-214. In a review of 24 controlled studies on the use of maintenance and antipsychotic drugs it was observed that 698 out of 1,068 patients who received placebos relapsed (65%), in contrast with 639 patients out of 2,127 who received maintenance antipsychotic drugs who relapsed (30%). The percentage of relapse in the drug-treated groups was less than half that observed in the control groups. Maintenance antipsychotic drugs would be indicated for prophylactic purposes in schizophrenic patients at risk for relapse. Tr. 60 at 140, 141 (Davis, "Overview: Maintenance Therapy in Psychiatry," *Amer. J. Psychiat.*, December, 1975 at p.1224).

J-215. The introduction of antipsychotic drugs, capable of preventing longstanding regressive states, has increased the number of relapses a patient is able to experience without developing chronicity. Tr. 57 at 70 (Brill).

J-216. Patients on antipsychotic drugs do not have more severe relapses than patients who have not been on drugs in the past. In fact, the patient treated with medication with some degree of insight will return for medication, preventing a more serious relapse. Tr. 57 at 69 (Brill).

(d.) *The Societal Impact of the Use of Antipsychotic Medications*

J-217. The widespread use of antipsychotic agents has contributed greatly to the reduction of patients residenced in mental hospitals. Tr. 57 at 39-40 (Brill); Tr. 29 at 56, 60 (DiMascio).

J-218. There never was a time in the history of the mental hospitals, which goes back for some 200 years, when there had been a reduction of population before the introduction of antipsychotic drugs, despite efforts to do away with the hospitals, to close the hospitals, or to reduce their populations. Tr. 61 at 37-38 (Brill).

J-219. As antipsychotic drugs were introduced, the in-

crease of population stopped, the behavior in the hospitals improved and subsequently there has been a decrease of mental hospital population of rather spectacular proportions. Tr. 57 at 39-40 (Brill).

J-220. In New York State, for example, populations at mental hospitals had been rising by 2,000 patients per year before the introduction of antipsychotic drugs. After the introduction of antipsychotic drugs, the population began to drop 500 patients per year. During this period, there was no change in administrative policy, staffing or financing. Tr. 57 at 39-40 (Brill).

J-221. Clinical experience and statistics point to a spectacular decrease in long-term mental illness since the introdution of antipsychotic drugs.

For example, there were 550,000 people in mental hospitals in the United States in '55. There are now less than 200,000. In New York there were over 90,000. Today, there is somewhere in the neighborhood of 28,000. Tr. 57 at 72 (Brill).

J-222. Forcible medication, when medications were introduced in the 1950's, allowed some chronic patients who had been in the hospital for 20-30 years to so improve that they were released from the hospital. Tr. 52 at 57-61 (deMarneffe).

J-223. The widespread use of pharmacotherapeutic agents has reduced the duration of hospitalization for patients at mental hospitals to a fraction of the previous duration. Tr. 57 at 41 (Brill); Tr. 29 at 61 (DiMascio).

J-224. Before the widespread use of anitpsychotic medications, it was unusual for an individual with schizophrenia to leave the hospital with less than four to six months of treatment. Today, the same type of individual at the same type of location is likely to be released in a period of a couple of weeks. Tr. 57 at 42 (Brill).

J-225. The widespread use of pharmacotherapeutic agents has made community based programs possible. Tr. 57 at 42 (Brill); Tr. 29 at 61-62 (DiMascio).

(e.) *Antipsychotic Medications as They relate to Other Psychiatric Therapies*

J-226. Antipsychotic drugs bring the patient within range of other methods of treatment. Tr. 57 at 52 (Brill).

J-227. It is impossible to deal with a disturbed or withdrawn actively psychotic individual unless one can establish a relationship with him, and that has to be done by bringing him out of the psychosis with medication to a sufficient degree to reach him. Tr. 57 at 52 (Brill).

J-228. It is doubtful that individual or group therapy, milieu approaches, or community mental health programs are feasible for schizophrenics without effective pharmacotherapy. Tr. 35 at 105-106 (Klerman, "Pharmacotherapy of Schizophrenia", *Ann. Rev. of Med.*, Vol. 25, 1974, p.199).

J-229. Patients can receive psychological therapies and drug therapies jointly, and it is, therefore, a false dichotomy to think of one versus the other. There is substantial evidence that psychological therapies improve social adjustment; however, the antipsychotic effects of the neuroleptics used either in the acute or maintenance situation are independent of the effects of psychotherapy. Psychotherapy in no sense substitutes for drug treatment. Tr. 60 at 139, 140 (Davis, "Overview: Maintenance Therapy in Psychiatry," *Amer. J. Psychiat.*, December, 1975, at p.1244).

J-230. It is an error to assume that the chronic use of medication prevents psychotherapeutic success. Not infrequently, this belief masks a Messianic attitude that the patient's improvement should be entirely attributable to the inspired personal impact of the therapist. Clinically there is no evidence to support this belief, and a great deal of clinical experience indicates that adequate medication may make fruitful psychotherapy possible. Tr. 35 at 100 (Klein and Davis, *Diagnosis and Drug Treatment of Psychiatric Disorders*, [1969] p.147).

J-231. When the results of milieu therapy, group

psychotherapy and individual psychotherapy were compared with neuroleptic drug treatment in schizophrenic patients, most studies demonstrated clearly the greatest improvement occurred with pharmacological therapy; there is also evidence of a combination of psychotherapy and other social therapies being more effective than pharmacological therapy alone, particularly during the rehabilitation and maintenance phases of treatment, after the acute symptoms of psychotic disorder have abated. Tr. at 142 (Lehmann, H., "Psychopharmacological Treatment of Schizophrenia," *Schizophrenia Bulletin*, [Summer, 1975] at p.31) Tr. 35 at 89-97 (DiMascio) (Klein and Davis, *Diagnosis and Drug Treatment of Psychiatric Disorders*, [1969] p.91-93).

J-232. The use of restraints such as seclusion, physical restraints, and electroshock treatment, have been dramatically reduced since the introduction of pharmacotherapeutic agents at the mental hospitals. Tr. 57 at 44 (Brill); Tr. 30 at 36 (Rundle - re. seclusion and restraints).

J-233. In one study, the number of patients in restraint and seclusion following the introduction of psychotropic medication dropped about 90 percent. Tr. 57 at 44 (Brill).

(f.) *Antipsychotic Medication - Potential Negative Effects*

J-234. Despite their known side effects the use of antipsychotic drugs as treatment is recognized and generally practiced by the psychiatric profession. Tr. 57 at 86 (Brill).

J-235. All therapeutically active drugs (all pharmacologically active drugs) have side effects in some persons at some time. Tr. 57 at 86 (Brill).

J-236. Most of the side effects of psychopharmacotherapy are minor. Tr. 57 at 82 (Brill).

J-237. Dry mouth, constipation, blurred vision, and somnolence (at the beginning of prescription) are all minor side effects. Tr. 57 at 83 (Brill).

J-238. Akinesia and akathisia are uncommon side effects of psychotherapeutic medication. Tr. 57 at 83 (Brill).

J-239. The side effect of akinesia is treatable either by lowering the dose of the neuroleptic or by the addition of an antiparkinson drug. Tr. 29 at 43 (DiMascio).

J-240. The side effect, "akathisia", will go away over time. Tr. 29 at 44-45 (DiMascio).

J-241. The extrapyramidal side effects of parkinsonism, dystonia and akathisia caused by pharmacotherapy are short lived and should respond to antiparkinsonism medication. Tr. 57 at 83 (Brill).

J-242. Parkinson-like side effects are transient and will frequently disappear even on the same dosage of a drug. Tr. 29 at 43 (DiMascio).

J-243. The side effect dystonia is not painful to the patient, and usually only occurs in the first few days of treatment. Tr. 29 at 44 (DiMascio).

J-244. Autonomic effects are usually transient, disappearing seven to ten days after the medication is first administered. Tr. 6 at 7-8 (Szlyk).

J-245. Paradoxical reactions, by definition, are uncommon. Tr. 57 at 76 (Brill).

J-246. Pendular and paradoxical reactions to antipsychotic medication are reversible. Tr. 37 at 12-14 (DiMascio).

J-247. Tardive dyskinesia is not indefinitely irreversible. Tr. 57 at 89 (Brill).

J-248. New Chemical treatments may reverse tardive dyskinesia in the future. Tr. 57 at 89 (Brill).

J-249. It is not known whether tardive dyskinesia is irreversible, as there are recent reports suggesting some drugs that may reverse it. Tr. 13 at 109 (Kantar).

J-250. Some patients show what appears to be withdrawal dyskinesia, which is limited to a period of several weeks following reduction or discontinuation of antipsychotic drugs. During one seven to ten month follow up study of 273 patients with tardive dyskinesia whose anxiety-psychotic medications

were discontinued, dyskinesia has disappeared in 15 percent and was reduced in 19 percent and remained unchanged in 55 percent. In another study all signs of dyskinesia regressed, more or less, completely within three years of discontinuation of antipsychotic drugs. Tr. 19 at 69-70 (Marsden, Tarsy and Baldessarini, "Spontaneous and Drug Induced Movement Disorders in Psychotic Patients," in Benson and Blumer, [eds], *Psychiatric Aspects of Neurologic Disease*, at 236).

J-251. To make clear whether most of the tardive dyskinesias are really irreversible, a long-term follow up study on the patients with tardive dyskinesia was performed. (1) In a half of the patients, especially in young adults, the symptoms completely disappeared after discontinuation of neuroleptic therapy, the duration of abnormal movements ranging from a few weeks to several years. (2) Even in some patients with severe irreversible dyskinesias the symptoms were considerably improved after the removal of neuroleptics. These findings indicate that irreversible dyskinesia can be confirmed only after long-term observation of the symptoms for several years under the removal of neuroleptics. Tr. 19 at 70-71 (Kauff).

J-252. Many patients suffering from tardive dyskinesia exhibit only subtle signs, and experience no serious disability. Tr. 57 at 121-122 (Brill).

J-253. A high percentage of patients who have received antipsychotic medication do not have tardive dyskinesia which is disabling to them. Tr. 57 at 122 (Brill).

J-254. Most patients with tardive dyskinesia suffer only from a small movement around the mouth or a small movement around the tongue. Tr. 57 at 122-123 (Brill).

J-255. Patients experiencing tardive dyskinesia, even when well-marked, do not complain about the movements. Tr. 57 at 123 (Brill).

(2.) *Forced and Involuntary Medication Furthers Cooperation in Other Treatments*

J-256. Any comprehensive treatment plan to be effective

requires a degree of cooperation by the patient. Some procedures incidental to the plan require more cooperation than others. It is possible, for example, to give patients medication without their cooperation and this may be done in an effort to make the patient more cooperative and receptive to other treatment procedures. Tr. 54 at 133-134 (deMarneffe) (APA, Position Statement on the Question of Adequacy of Treatment, 123 *Amer. J. Psychiat.*, [1967] p. 1458); Tr. 60 at 137 (Kahn).

J-257. At times, involuntary medication facilitates the therapeutic alliance. Tr. 14 at 29 (Kantar).

J-258. Mental patients refusing their antipsychotic medications frequently also refuse all offered treatment, physical examination, even contact with other people. They refuse to communicate. They withdraw and build a barrier or a defense of hostility to any approach. This is usually out of fear, out of a delusional structure. Tr. 57 at 95 (Brill).

J-259. Some patients can only begin to cooperate voluntarily when medication supresses the psychosis and allows the well part of the personality to come into play. Tr. 57 at 94-95 (Brill).

J-260. Patients often can only begin to cooperate voluntarily after involuntary medication. Tr. 29 at 63 (DiMascio).

J-261. Forcing medication on an incompetent patient is not going to jeopardize treatment in the future. Tr. 30 at 65 (Rundle).

(3.) *The Failure to Forcibly or Involuntarily Medicate an Individual Patient Affects the Entire Milieu of the Hospital*

J-262. One patient refusing medication usually becomes known to other patients. This sets off a sort of contagion of refusal. Tr. 66 at 79 (Gill).

J-263. The failure to forcibly medicate an individual patient refusing medication would affect the entire milieu of the hospital. By letting things develop to a point where there is a life-threatening situation, not only is the patient's own in-

dividual condition jeopardized, but also in all probability there will be a serious impact on the rest of the institution. Tr. 52 at 56 (deMarneffe).

(4.) *The Vast Majority of Patients Refusing Antipsychotic Medication Do So for Irrational Reasons Relating to Their Illness*

J-264. The vast majority of patients who need involuntary or forcible medication are not particularly rational, particularly in regard to taking something into their bodies. Tr. 64 at 53 (Gill).

J-265. The vast majority of the patients at the Austin Unit who have refused antipsychotic medication have done so because they deny that they are mentally ill and lack insight into the seriousness of their problem by reason of their illness. Tr. 66 at 32-33 (Gill).

J-266. Many patients refuse antipsychotic medication because they wrongly think that they are beyond help. Tr. 57 at 96 (Brill).

J-267. Patients refuse their antipsychotic medication because of paranoia. Tr. 36 at 63 (Whitaker); Tr. 36 at 65 (VanPutten, "Why Do Schizophrenic Patients Refuse to Take Their Drugs", 31 *Archives of General Psychiatry* [July, 1974] p. 67).

J-268. Patients refuse their antipsychotic medication because they use their drugs as a convenient focal point for hostile and aggressive impulses. Tr. 36 at 65 (VanPutten, "Why Do Schizophrenic Patients Refuse to Take Their Drugs", 31 *Archives of General Psychiatry* [July, 1974] p. 67).

J-269. Those patients who are the most ill are the most likely to refuse their medication. Tr. 36 at 66, 72 (VanPutten, "Why Do Schizophrenic Patients Refuse to Take Their Drugs", 31 *Archives of General Psychiatry* [July, 1974] p. 68); (VanPutten, "Drug Refusal in Schizophrenia and the Wish to be Crazy", 33 *Archives of General Psychiatry* [Dec., 1976]).

J-270. One of the most important reasons for patients

refusing their antipsychotic medications is because acceptance of medication forces the patient to admit that he is sick. Tr. 36 at 66 (Van Putten, "Why Do Schizophrenic Patients Refuse to Take Their Drugs", 31 *Archives of General Psychiatry* [July, 1974] p. 68).

J-271. Drug refusers have less insight into their illness than persons accepting antipsychotic medication. Tr. 36 at 71 (VanPutten, "Drug Refusal in Schizophrenia and the Wish to Be Crazy," 33 *Archives of General Psychiatry* [Dec., 1976]).

J-272. Drug refusers are hospitalized more against their will than drug acceptors. Tr. 36 at 71-72 (VanPutten, "Drug Refusal in Schizophrenia and the Wish to Be Crazy," 33 *Archives of General Psychiatry* [Dec., 1976]).

J-273. Patients do not usually refuse their medication because of the pain of an intramuscular injection, as the patients usually first refuse the medication when it is offered to them orally. Tr. 36 at 58 (Whitaker).

J-274. Patients do not usually refuse their medications because of sedative effects. Tr. 36 at 59, 60 (VanPutten, "Why Do Schizophrenic Patients Refuse to Take Their Drugs", 31 *Archives of General Psychiatry* [July, 1974] p. 71).

(5.) *Forcibly and Involuntarily Medicating a Psychotic Patient Settles the Patient Down and Reassures the Patient that Someone will Take Care of Him, as a Classic Symptom of Severe Mental Illness is Ambivalence Toward Treatment*

J-275. Mental patients in state hospitals suffer from a condition which is described as ambivalence, that is, profoundly and powerfully mixed and opposing feelings. Mental patients, unlike normal people, cannot resolve their ambivalence, and it places them in a great deal of turmoil. Tr. 64 at 56-57 (Gill).

J-276. It is hard to say that intramuscular medication is forcible because psychotic patients seem to want the staff to take over and to be firm about their treatments. Oftentimes when the staff demonstrates firmness and a willingness to take over as a way of engaging the patient in a relationship, the patient settles down remarkably. Tr. 64 at 50 (Gill).

J-277. Telling a patient in a panic state that he or she will be given medication forcibly if they do not take it orally often settles the patient down, giving the patient a sense of relief that someone is helping them. Tr. 6 at 43a (Szlyk).

J-278. One of the things that is very troublesome to a person who has become psychotic is the anxiety that they will not be able to be controlled. The recognition that there is a place and there are people who will control them and help them regain and reorganize themselves is extremely reassuring. Tr. 11 at 133 (Kantar).

J-279. After a forceful stand is taken regarding medication, patients then usually take the medication voluntarily in the future. Tr. 66 at 66 (Gill). The patients relinquish their ambivalence toward their treatment and feel they have proven that the hospital staff will take responsibility for them. Tr. 66 at 69-70 (Gill).

J-280. After treatment with antipsychotic medication, patients are grateful for the relief of the tension and for the relief of the aggression which they usually feel as an uncomfortable sensation. Tr. 57 at 14 (Brill).

J-281. Many patients who have been forcibly medicated against their will later thank their doctor or their nurse for having overridden their refusal. Tr. 57 at 96 (Brill); Tr. 52 at 56 (deMarneffe);Tr. 64 at 50 (Gill).

(6.) *The Decision Whether to Forcibly Medicate Should Be Left to the Doctor, Subject to Review if Abused, as it is the Doctor, and not a Sick Mental Patient or a Disinterested, Unavailable Guardian, Who Has the Best Interest of the Patient in Mind.*

J-282. In general, the doctor is in a better position than the sick mental patient at a state hospital to decide what is in the patient's best interests. Tr. 52 at 5 (Olin).

(H.) Reasons for Forcibly Medicating Both Involuntary and Voluntary Patients in Situations that do not Pose A Serious Threat of Personal Injury to Themselves or Others

1. *The Failure to Forcibly or Involuntarily Medicate in Situations that Do Not Pose a Serious Threat of Personal Injury to the Patient or Others Would Leave Patients to Suffer Severe Psychic Pain That Could Have Been Treated With Medication*

J-283. The failure to involuntarily medicate patients who are acutely psychotic in a state of psychiatric emergency but who do not pose a serious threat of personal injury to themselves or others creates unnecessary pain and panic for the patients. Tr. 12 at 120 (Kantar).

J-284. Allowing a psychotic patient to refuse treatment is keeping a person severely ill, and preventing the person from regaining his or her health. Tr. 57 at 10 (Brill).

J-285. Patients treated with antipsychotic medications are relieved to be rid of the intense suffering that is the subjective component of psychosis. To be psychotic is to suffer severely. Tr. 57 at 59 (Brill).

J-286. While a patient's psychosis may not pose a serious threat of personal injury to the patient or others, the psychosis can create an enormous panic perceived by the patient as life threatening in quality. The panic creates an extraordinarily uncomfortable state for the patient which can be relieved by the administration of medication. Tr. 12 at 120 (Kantar).

J-287. The psychotic patients, whether or not dangerous, experiences intense suffering. Tr. 66 at 5-6 (Gill); Tr. 51 at 421 (Olin).

J-288. People suffering from a psychiatric emergency, or in other words acutely psychotic patients, even if not constituting a serious threat of personal injury to themselves or others, are terrorized and in a state of internal panic, unbearable agony, pain and distress. Tr. 64 at 49-50 (Gill); Tr. 66 at 3-5 (Gill); Tr. 6 at 27-28 (Szlyk). The panic may manifest itself in various physical signs, such as a great deal of

hyper-ventilation, clenching their fists, rapid breathing, rapid pulse, sweating, pained facial expressions, or a terrorized look in the eyes. A patient may react to this panic by withdrawing or by extending the threat to others. This psychological pain may extend into a physical pain. Tr. 66 at 3-5 (Gill); Tr. 64 at 49-50 (Gill).

J-289. The outwardly calm patient can be suffering from intense terror within. The terror is not being expressed because the patient may have come to the conclusion that it is best to keep it hidden. Tr. 66 at 19 (Gill).

J-290. However, the person who calmly refuses medication over the course of a day is probably not in a state of psychiatric emergency. Tr. 66 at 61-62 (Gill).

(2.) *The Failure to Forcibly or Involuntarily Medicate in Situations That Do Not Pose a Serious Threat of Personal Injury to the Patient or Others Would Increase Chronicity and Lead to the Warehousing, Rather Than Treating, Those Severely Mentally Ill Patients Refusing Treatment*

J-291. The failure to forcibly medicate psychotic patients would return the psychiatric hospital to the days of warehousing. Tr. 52 at 40 (Olin).

J-292. The ultimate logic of honoring a mentally ill patient's refusal of treatment, as recognized by Dr. Rundle, is to sit around and slowly let the patient die. See Tr. 30 at 69-75 (Rundle).

J-293. Patients with delusion of grandeur left untreated eventually will be returned to the mental hospital by police or despairing relatives. Tr. 36 at 74-75 (VanPatten, "Drug Refusal in Schizophrenia and the Wish to Be Crazy", 33 *Archives of General Psychiatry* [Dec., 1976], p. 1446).

J-294. Patients whose psychotic symptoms include withdrawal do not necessarily behave in an assaultive manner at some point in the future if they are untreated. Although some withdrawn patients may eventually become assaultive, others may simply become unresponsive to verbal interaction and remain unmoving in bed. Tr. 58 at 52 (Seil)

J-295. Certain patients who refuse treatment are mute, stuporous or in a catatonic state. Although their condition does not pose a serious threat of personal injury to themselves or others, such patients are unavailable to the contacts people are trying to make with the patient. They are not able to tell people of their ailments, physical and psychological, and they need to be treated. Tr. 64 at 55-56 (Gill).

J-296. Not to forcibly medicate a psychotic patient early in his illness is to invite chronicity. Tr. 52 at 40 (Olin).

J-297. Acute psychosis may be treated quickly and effectively and must be recognized as a condition that demands rapid and decisive intervention. Delayed treatment may contribute to the development of certain features indicative of a chronic condition. Tr. 60 at 90, 91 (Anderson and Kuehnle, "Strategies for the Treatment of Acute Pyschosis", *J.A.M.A.*, Sept. 30, 1974, pp. 1886, 1889).

J-298. Nobody suffering from a chronic or rapidly relapsing psychotic state can indefinitely maintain a position in society or with a family. Tr. 57 at 68-69 (Brill).

(3.) *The Failure to Forcibly or Involuntarily Medicate in Situations That Do Not Pose a Serious Threat to the Patient or Others Would Lead to an Increase in Violence in the Hospital*

(a.) All Acutely Psychotic Patients Have the Potential for Impulsively Committing a Dangerous Act

J-299. Optimal treatment implies the most rapid possible alleviation of psychosis. The acutely psychotic individual is in constant danger of impulsive suicide, homocide, self-mutilation or otherwise harmful behavior. This remains true whatever social or physical constraints are placed around him. Tr. 60 at 90, 91 (Anderson and Kuehnle, "Strategies for the Treatment of Acute Psychosis," *J.A.M.A.*, Sept. 30, 1974, at p. 1886).

J-300. Acute psychosis is an emergency because victims of such disorders are in constant danger of acting on distorted perceptions or delusional ideas, with the result that death or

injury may inadvertently occur. Tr. 60-90 (Anderson and Kuehnle, "Strategies for the Treatment of Acute Psychosis", *J.A.M.A.*, Sept. 30, 1974, at p. 1884).

J-301. Psychotic anxieties manifest themselves by confusional fear and fright and behavior which is completely out of proportion and which, like psychotic rage, make no sense and are often associated with a state of diminished consciousness. The individual becomes so terrified that he isn't really sure where he is or where he is going or what he is doing. He may fling himself before a car or fling himself off a building. Another reaction to psychotic anxiety is psychotic aggression because all of us become more dangerous when we are frightened. Tr. 57 at 10 (Brill).

J-302. When not medicated sufficiently early or sufficiently forcefully, patients tend to escalate. Patients in a state of decompensation or psychotic turmoil can escalate into a situation of actual violence. Tr. 65 at 111 (Gill).

(b.) *The Occurence of Violence In a Psychotic Patient is Not Always Predictable to a Probability*

J-303. The occurence of violence is not always predictable in an acutely psychotic patient to a probability. Tr. 66 at 60 (Gill).

J-304. While doctors have the ability to predict for some patients whether one act will later lead to a serious threat of violence, some patients do not have a sufficient history to allow doctors to predict violence to this same degree of probability. Tr. 65 at 97-98 (Gill). The doctors do know, however, that the medication should be beneficial to the patient, with the improvement in the patient preventing later violence which might have occured. See Proposed Findings J-152-255 re. the benefits of antipsychotic medication.

(c.) *The Potential for Violence Would Inevitably Manifest Itself Down the Road if Patients Were Not Forcibly Medicated Before They Posed Such a Serious Threat of Violence that Staff Would Be Justified in Secluding Them*

J-305. The failure to involuntarily medicate patients who are acutely psychotic in a state of psychiatric emergency, but who do not pose a serious threat of personal injury to themselves or others, increases the possibility of a serious threat to a patient or staff arising at a later date. Tr. 12 at 120 (Kantar).

J-306. The inability to forcibly medicate patients except when there is a serious threat of personal injury prevents staff from forcibly medicating patients that they believe might possibly commit a violent act but for whom they are not sure. Tr. 65 at 94-96 (Gill). This situation necessarily will lead to an increase in violence at state hospitals as staff are not always around to stop assaultive acts, when they do occur down the road.

J-307. When a patient represents a threat of violence six months down the road, while it would be proper to forcibly medicate that patient, one may not seclude that patient on that day. Tr. 58 at 52-56 (Seil).

(4.) *Forcibly and Involutarily Medicating Patients Only in Situations that Pose a Serious Threat of Personal Injury to Themselves or Others Would Create a Vicious Self-Defeating Cycle, in which Patients Were Never Given Enough Medication to Keep Their Severe and Dangerous Illness from Returning*

J-308. Not to forcibly medicate in circumstances which are not life threatening but when medication is necessary for the well-being of the patient would create a vicious self-defeating cycle. If you medicate a patient only in a life-threatening situation, the life-threatening situation disappears

as a result of the medication given. If the patient at that point refuses the medication, and if at that point the medication is discontinued, the patient in all probability will get worse, requiring the doctors to wait again until another life-threatening situation occurs before you can medicate the patient. Tr. 52 at 55-56 (deMarneffe).

J-309. While one shot of antipsychotic medication may deal with a temporary rage or terror, it is necessary to administer antipsychotic medication for a considerable period of time of four to eight weeks, for the medication to control psychosis. Shorter periods of administration will lead to a roller coaster effect with the patient deteriorating after the medication is stopped. Tr. 57 at 24-25 (Brill).

J-310. There are a large number of patients who are in intense psychotic turmoil, and if they are not treated, these patients become self-destructive or violent toward others. For those patients, involuntary treatment, not simply to restrain the acute emergency, but as the systematic application of medication to reduce the psychotic turmoil, is necessary to prevent acts of violence. The effect of such involuntary medication is not to sedate the patient for a period of time, but to rearrange the psychotic thought disorder which is long-standing and is not immediately reversible. Tr. 60 at 92, 93 (Kahn).

J-311. If a doctor can only forcibly medicate once to meet a serious threat of physical injury, while the medication may calm the patient down for a day or so, the medication is not sufficient to keep the patient's severe illness from returning after that. Tr. 66 at 11-12 (Gill).

J-312. In order for antipsychotic drugs to be effective, the patient must be on a therapeutic regimen of medication. While one injection might calm down an agitated patient, one injection is not enough to create a continual therapeutic tissue level of the drug. Tr. 58 at 16 (Seil).

J-313. The treatment of schizophrenia with antipsychotic

drugs does not consist of the sedation of a patient with a massive amount of medicine, but rather, the short-term, but repeated administration of medication over usually an eight to nine week period of time, the build-up of the medicine thereby producing a normalization of thought processes. Tr. 60 at 144, 147 (Kahn).

J-314. The maintenance treatement of schizophrenia with antipsychotic drugs consists of treatment of months or years or a lifetime, as one treats diabetes for a lifetime. Tr. 60 at 144 (Kahn).

J-315. The relatively slow onset of anitpsychotic effect cannot be overemphasized. The time course of response to anitpsychotic drugs is such that three weeks or more is required to demonstrate positive effects in hospitalized schizophrenics. Full effect may require six weeks to six months. Tr. 60 at 145, 146 (Goodman & Gilman, The *Pharmacological Basis of Therapeutics*, 5th ed., [1975] at p. 173).

J-316. Based on results of the NIMH Collaborative Study, 95 percent of acutely hospitalized patients on antipsychotic medications will show some discernable degree of clinical improvement within six to eight weeks. During that period, about half the patients can be expected to be markedly or moderately improved. The period of hospitalization for most acutely psychotic patients is now less than three months, a marked reduction over previous practices. Tr. 35 at 106 (Klerman, "Pharmacotherapy of Schizophrenia", *Ann. Rev. of Med.* Vol. 25, 1974, p. 199).

(5.) *The Requirement to Pose A Question Other than Whether Forcible or Involuntary Medication is Medically Indicated Would Lead to Uncertainty on the Part of the Staff with a Concommitant Deterioration in the Condition of the Patients*

J-317. The inability to forcibly medicate patients except when there is a serious threat of personal injury necessary will lead to uncertainty on the part of staff as to what they can do.

Patients are exquisitely sensitive to this uncertainty and they then become mistrustful of the staff's intentions and ability to control them. Tr. 65 at 88-89 (Gill).

(6.) *The Effects of the Temporary Restraining Order in this Case Demonstrate the Need to Allow Patients to be Forcibly and Involuntarily Medicated in Situations Other than Only Those Which Pose a Serious Threat of Personal Injury to the Patient or Others*

(a) *General*

J-318. On April 30, 1975, this Court issued a temporary restraining order restraining the defendants from forcibly confining in seclusion or medicating the plaintiffs and all other inpatients of the Austin and May Units without their consent or the consent of their guardians except where there is a serious threat of or as a result of extreme violence, personal injury or attempted suicide.

J-319. The temporary restraining order in this case had a deleterious effect upon patient care at the May Unit. Tr. 58 at 31 (Sell).

J-320. The change in medication practice at the Austin Unit dictated by the temporary restraining order created increased tension and situations that were extremely difficult and dangerous. Tr. 65 at 88 (Gill).

(b.) *The Temporary Restraining Order Required a Change in Medication Practices at the Austin and May Units.*

J-321. After the temporary restraining order, the definition of emergency justifying involuntary or forcible medication was narrowed. Tr. 11 at 158 (Kantar).

J-322. Prior to the temporary restraining order, physicians were able to medicate a patient against his or her will in a psychiatric emergency. After the temporary restraining order, physicians were able to medicate a patient against his or her will only in a physical emergency. Tr. 65 at 101 (Gill).

J-323. Prior to the temporary restaining order, different

standards were used to determine when to forcibly medicate a patient than to determine when to seclude a patient. Tr. 65 at 96 (Gill).

J-324. Prior to the temporary restraining order, the staff looked for a clearer demonstration of physical danger before secluding a patient than was required to justify forcibly medicating a patient. Tr. 65 at 97 (Gill).

J-325. The temporary restraining order imposed the same standard for determining when to forcibly medicate as that for determining when to seclude. Tr. 65 at 97 (Gill).

J-326. After the temporary restraining order, the situation had to be more drastic than before the temporary restraining order to intervene with forcible or involuntary medications. Tr. 110 at 165 (Kantar).

J-327. After the issuance of the temporary restraining order, staff members at the Austin Unit were unable to forcibly medicate patients who were in an ongoing psychiatric emergency, but who were not violent, threatening violence, or suicidal. Tr. 41 at 3 (Crane).

J-328. After the temporary restraining order a patient would only be medicated when he or she presented a serious threat of violence. Before the temporary restraining order, the patients were medicated for other reasons, such as in psychiatric emergencies to prevent the deterioration of a patient. Tr. 58 at 43-44, 45-47, 50-51, 52-55, 59-60 (Seil).

(c.) *The Change in Medication Practices Required by the Temporary Restraining Order Negatively Affected the Condition of Specific Patients.*

((1)) *After the Issuance of the Temporary Restraining Order, Many Patients Refused Their Medication.*

J-329. After the temporary restraining order, many patients at the Austin Unit refused medication, more than had refused medication prior to the temporary restraining order. Tr. 65 at 88, 89 (Gill).

J-330. On any given date since the temporary restraining order, approximately 10 to 12 patients have refused medication. Tr. 66 at 71 (Gill).

J-331. Between May 1, 1975, through the summer of 1977, Dr. Gill is able to recall at least 89 patients at the Austin Unit who refused antipsychotic medication and suffered serious physical or mental consequences as the result of that refusal. Tr. 66 at 70 (Gill).

J-332. Following the issuance of the temporary restraining order, a great many patients at the May Unit began to refuse their medication. Most of the patients who refused only did so for a short period of time. However, there were a core of patients who decided to stay off medication, and the mental conditions of these patients deteriorated. Tr. 58 at 32, 33 (Seil).

((2)) *The Inability to Involuntarily Medicate Patients In Psychiatric Emergencies Not Constituting Threat of Violence at the Time Resulted in Acts of Violence by Some Patients Down the Road.*

J-333. Some patients who were involuntarily medicated prior to the issuance of the temporary restraining order when in a psychiatric emergency, were not able to be involuntarily medicated thereafter in those circumstances, because while *potentially* violent, they did not pose a *serious* threat of violence. Tr. 66 at 67 (Gill).

J-334. For example, F.T., a chronic Austin Unit patient, refused antipsychotic medication after the temporary restraining order, but was not forcibly medicated because she had no clear history of violence and was only potentially violent. She continued to refuse medication and despite close monitoring of her behavior, set herself on fire. Tr. 66 at 67 (Gill).

J-335. Similarly, the Austin Unit patient J.T. had no history of violence, but had been involuntarily given medication during earlier admissions when he was in a psychiatric emergency state with a resulting amelioration of his acute

psychotic state. When he was admitted in the fall of 1975, in an emergency psychiatric state, he refused antipsychotic medication and was not forcibly medicated because he had no prior history of violence. He eventually so deteriorated that he violently attacked an attendant, which fractured the attendant's face and required surgery. If J.T. had been forcibly given antipsychotic medication early in his admission, his violent behavior would probably have been prevented. Tr. 65 at 90-93, 96; Tr. 65 at 47-49 (Gill).

J-336. The female patient A.M. had had no prior history of assaultiveness and was not forcibly medicated when she refused antipsychotic medications after the temporary restraining order. Over several weeks of persistant refusal, she became more withdrawn, paranoid, and suspicious and began to spit or yell at anyone who came near her, until she eventually became assaultive. Tr. 65 at 123-126 (Gill).

J-337. G.J., a female patient at the May Unit and Solomon Carter Fuller Mental Health Center, often walked a very thin line of being dangerous to herself or to others. While prior to the temporary restraining order she had been forcibly medicated under these circumstances, thereafter she was forcibly medicated only when she presented a clear, serious threat of violence. After the temporary restraining order, when refusing medication, she eventually became assaultive and was sent to Framingham. Tr. 58 at 43-44 (Seil).

J-338. C.T., a male patient at the May Unit and Solomon Carter Fuller Mental Health Center refused his medications after the temporary restraining order and his mental condition began to deteriorate. He began to abuse his physical condition; his hygiene deteriorated markedly; and he became frightening to persons he visited outside the institution. Whereas prior to the temporary restraining order he had been forcibly medicated immediately at the point he began to deteriorate, he could not be forcibly medicated during this period of time because he did not pose a serious threat of per-

sonal injury, extreme violence or attempted suicide at any one time. He refused all other forms of treatment and was discharged from the hospital, whereupon he set a fire in the South End, and was sent to Bridgewater State Hospital. Tr. 58 at 45-47 (Seil).

((3)) *Some Patients Refusing Medication Did Not Receive Inpatient Care Because the Temporary Restraining Order Prevented the Staff From Providing Adequate Treatment Which Necessarily Would Have Included the Use Of Medication.*

J-339. Between May 1, 1975, through the summer of 1975, at least 14 patients who had previously been admitted to the Austin Unit were denied admission because they were known to have refused treatment after the temporary restraining order and it was believed they could not be adequately cared for under the temporary restraining order. Tr. 66 at 71 (Gill).

J-340. After the issuance of the temporary restraining order, some patients who, as the result of refusing medication, were also refusing all other forms of treatment offered, had to be released from the May Unit and the Solomon Carter Fuller Mental Health Center. (There were a number of other patients, however, who were refusing treatment and yet could not be released because the expectation of their survival in the community was so low it precluded release from the protective custody of the hospital.) Tr. 58 at 33, 34 (Seil).

J-340A. When C.T. refused medication after the temporary restraining order, he increasingly refused all other forms of treatment and had to be discharged from the May Unit. Tr. 58 at 45-47 (Seil). See Proposed Finding J-338 for C.T.'s history.

J-341. Despite her need for treatment, including medication and personal contact, Rubie Rogers began refusing medication, individual treatment, and group therapy follow-

ing the issuance of the temporary restraining order. She became physically and verbally assaultive to patients and staff, and because of her refusal of all treatment, was discharged on May 7, 1975. Tr. 56 at 46, 47 (Cacciola); Pl. Ex. 9, Doc. Nos. 500033, 500146.

((4)) *The Temporary Restraining Order Prevented Maintaining a Patient on a Sustained Regimen of Antipsychotic Medication to Decrease a Psychotic Process.*

J-342. After the temporary restraining order, there were Austin Unit patients who were forcibly medicated when they constituted a serious threat of violence, improved sufficiently from the single dose of medication so as to not constitute a physical emergency, continued to refuse the medication, and then deteriorated again because of their failure to be on sustained medication. Tr. 66 at 68 (Gill).

J-343. G.E., for example, was a young male patient who had a series of admissions to the Austin Unit and was episodically violent. After the temporary restraining order, he was admitted and refused to take medication voluntarily. He was forcibly medicated on two occasions when he became assaultive. He was calm for a period of days thereafter and then deteriorated to another episode of violence, when he was again forcibly medicated. The staff was unable to give him a continuous regimen of medication and he escaped. Tr. 66 at 68, 69 (Gill).

J-344. The female patient P.B. was admitted to the Solomon Carter Fuller Mental Health Center on two separate occasions following the issuance of the temporary restraining order. During both of these admissions she refused antipsychotic medications. During the first admission she was forcibly medicated on one or two occasions when she was assaultive, but this medication was not sufficient to reverse her psychotic process. Because of the temporary restraining order, the staff was not able to give her a continuous regimen of

medication until a court order for medication was issued. She was then forcibly medicated for five days, at which time she began to take the medication voluntarily. Within one or two weeks of regular medications beginning, she recompensated and was able to be discharged from the hospital. On a second admission, she again refused antipsychotic medication and, over a period lasting six weeks to two months, was forcibly medicated only when she was assaultive, in accordance with the terms of the temporary restraining order. The administrations of medication clamed her down a bit on each occasion, but were of limited value in improving her overall condition. After she agreed to take medication voluntarily, she was able to be discharged within approximately one week. Tr. 58 at 47-50 (Seil).

J-345. When Rubie Rogers refused medication and was assaultive following the issuance of the temporary restraining order, she was on occasion forcibly medicated. This helped calm her down, but it did not constitute the therapeutic regimen of medication she required. Tr. 58 at 16 (Seil).

((5)) *The Temporary Restraining Order Resulted in Increased Lengths of Stay and Prolonged Unnecessary Psychic Suffering for Some Patients.*

J-346. Between May 1, 1975, through the summer of 1977, Dr. Gill recalls at least 56 patients at the Austin Unit who refused medication and had their hospitalizations prolonged, although they did not suffer serious physical or mental consequences as the result of their refusal. Tr. 66 at 70, 71 (Gill).

J-347. After the temporary restraining order, there were Austin Unit patients who refused medication, did not constitute a serious threat of personal injury at any time during their refusal, but remained acutely psychotic for months while not receiving medication. Tr. 66 at 67, 68 (Gill).

J-348. The female patient E.M., for example, refused medication and remained in an acutely psychotic, paranoid state, withdrawn, hostile, suspicious, and resistant to approach by anyone from July, 1977, until February, 1978. Because she did not represent a threat of violence to herself or others, she could not be forcibly medicated. In February, 1978, seven months after first seeking a guardian, her sister became her guardian. Tr. 66 at 68 (Gill).

J-349. The female patient J.R. had been involuntarily medicated at the Austin Unit during admissions prior to the temporary restraining order and had required only four to six weeks of hospitalization before being discharged. After the temporary restraining order she was admitted, in a severely regressed acutely psychotic state, paranoid, delusional, refusing medication, feeling that staff were poisoning her and that she was a man. Although in a state of psychiatric emergency, she did not represent an emergency as defined by the temporary restraining order and was not, therefore, involuntarily medicated. Because she did not receive antipsychotic medication, she remained in the hospital nearly six months, her mental status deteriorating further, until she was severely beaten by a male patient whose clothing she had stolen and was wearing. Tr. 40 at 103-104 (Herschel).

J-350. Had the staff at the Solomon Carter Fuller Mental Health Center been able to institute a continuous regimen of medication for P.B. upon both of her admissions following the temporary restraining order, she would have been discharged from the hospital within a week or two, rather than, on her first admission, five to six weeks, and, on her second admission, approximately two months. Tr. 58 at 47-50 (Seil). See Proposed Finding J-344 for J.B.'s history.

J-351. A.H. is a woman in her late forties who has been hospitalized in a similar pattern at the Solomon Carter Fuller Mental Health Center twice a year for the past seven years. During admissions prior to the temporary restraining order,

she would initially refuse medication, but the staff, knowing her well, recognized this as a one-time battle, and would forcibly medicate her. After being forcibly medicated once, she would voluntarily continue the medication and would be discharged after a brief stay. During an admission shortly after the issuance of the temporary restraining order, A.H. was allowed to refuse medication for several months because her behavior, although psychotic, did not constitute a serious threat of extreme violence, personal injury, or attempted suicide. She remained psychotic and abusive; her personal hygiene deteriorated. Only after she was assaulted by another patient because of her abusive manner of dealing with others, was the determination made to give her forced medication for her own protection. Thereafter, she began to take her medication voluntarily and was discharged. Tr. 58 at 52-55 (Seil).

J-352. W.R. is a twenty-two year old male patient who came to the Solomon Carter Fuller Mental Health Center in July, 1978, on his first psychiatric hospitalization and whose inpatient stay was doubled because of inability of the staff to involuntarily medicate him under the terms of the temporary restraining order. Prior to his admission, W.R. had dropped out of college, barricaded himself in his room, and became uncommunicative with his parents. He had developed bizarre paranoid thinking about neighbors and hallucinated about imaginary people in the yard, clearly acting as if he was in danger. Committed through a physician, he was frightened, not communicating with staff, pacing, non-responsive, wandering around the ward with fingers in his ears and putting objects in his ears. His eating habits were poor and he had suffered a weight loss prior to admission. The staff concluded that psychotropic medication would clearly reduce his hallucinations and psychotic thinking, but, when offered medications, W.R. refused. W.R. was not forcibly medicated at that time because his condition did not constitute a serious threat of violence to himself or others on the ward. W.R. was

not forcibly medicated until one month later, when his mother was appointed guardian and authorized the administration of medication. He thereafter accepted medication on a regular basis, improved, was discharged one month later and found employment. Tr. 69 at 11-15 (Cox).

At the time W.R. was refusing medication, he was denying his illness, was unable to appreciate his condition, had no insight whatsoever into his illness or the seriousness of his situation. Tr. 69 at 12-13 (Cox).

While refusing antipsychotic medication, W.R. did not communicate and did not participate in group or individual therapy. Tr. 69 at 13 (Cox).

During the month that W.R. was an inpatient and not receiving antipsychotic medication, he was clearly suffering. Tr. 69 at 13, 15-16 (Cox).

Had the temporary restraining order not been in effect, W.R. would have been involuntarily medicated at the Solomon Carter Fuller Mental Health Center. Tr. 69 at 14 (Cox).

W.R.'s two-month stay in the hospital was lengthened by a month because he was not receiving antipsychotic medication for the first month of his hospitalization. Tr. 69 at 15-16 (Cox).

J-353. G.M., a mother of three in her mid-thirties, remained an inpatient at the Solomon Carter Fuller Mental Health Center four to five weeks while not receiving medication. During this time she was withdrawn, extremely frightened and huddled by the door clutching her suitcase, not taking off her coat or talking to anyone. As the probable result of paranoia, she refused medications and had difficulty eating. She denied she had children or a family. Although suffering, she could not be forcibly medicated because she did not represent a serious threat of extreme violence, personal injury or attempted suicide. Only after her husband was appointed guardian did she receive forcible medication for two to five days before beginning to take medication voluntarily. She then

began to be open, to smile, and to form relationships with the staff. Three to four weeks later she was able to be discharged. Tr. 58 at 56-60 (Seil).

J-354. The elderly female patient M.S., who had been receiving maintenance doses of antipsychotic medication, began to refuse medication after the temporary restraining order. Because she represented no threat of extreme violence, personal injury, or attempted suicide, she could not be forcibly medicated. As the result of receiving no medication, she deteriorated markedly. Her deterioration took the form of simply remaining in bed all day long and becoming abusive if anyone attempted to get her out of bed or to do anything with her. She was finally forcibly medicated because of the staff's concern that she might suffer damage to her skin by lying in bed all day; this was determined to represent a serious threat of personal injury to herself. Tr. 58 at 50-52 (Seil).

J-355. The inability of the Austin Unit staff to forcibly medicate J.T. prior to his physical attacks on attendants, see Proposed Finding of Fact J-335, prolonged his hospitalization and caused him to have a severe sense of guilt over what he had done. He became fearful of his aggressive impulses and afraid that he might rape women or attack people on the street and was, therefore, reluctant to leave the hospital. Tr. 65 at 90-93 (Gill).

(d.) *The Temporary Restraining Order Negatively Affected Ward Milieu and Interfered With the Treatment Relationships Between Patients and Staff.*

J-356. Since the issuance of the temporary restraining order, patients' tensions, threats, agitation and acts of violence have increased in the Austin Unit. Tr. 68 at 29 (Gill).

J-357. After the temporary restraining order, violence has increased at the Austin Unit. Patients and staff expect to be hit. There is an atmosphere of violence on the wards, which did not exist before. Tr. 65 at 89, 90 (Gill).

J-358. The temporary restraining order created an adversarial situation between patients and staff at the Austin Unit. The patients looked upon staff as their adversaries, rather than people trying to help. The patients were much less trusting to staff. Tr. 65 at 89 (Gill).

J-359. The temporary restraining order helped establish an adversarial relationship between patients and staff. Tr. 58 at 33-35 (Seil).

J-360. Patients, many of whom had paranoid ideas already as a consequence of their illness, began to distrust the staff a great deal. Those many patients who have an initial hostility towards everyone, including the staff, were enabled to express that hostility by refusing medication. Tr. 58 at 33-35 (Seil).

J-361. Following the issuance of the temporary restraining order, May Unit staff were afraid to intervene with patients for fear that the patients might take this to mean they were trampling on the rights of patients. Tr. 58 at 33 (Seil).

J-362. The temporary restraining order caused staff at the Austin Unit to be uncertain as to the appropriate course of action to take in managing patients. Because patients are very sensitive to uncertainty or ambivalence in staff, patients picked up that uncertainty very quickly and became very distrustful. Tr. 65 at 89 (Gill).

J-363. Refusal of medication by a patient affected the behavior of other patients at the May Unit. If the condition of the refusing patient were deteriorating, other patients wondered why the staff was not doing anything for the patient; if the patient were hostile, the other patients wondered why the the staff was not controlling him or her. Tr. 58 at 127, 128 (Seil).

J-364. Because of the temporary restraining order, many patients at the Austin Unit who were refusing medication were not asked firmly or told firmly to take medication and, consequently, either deteriorated in their condition or their situa-

tion worsened so they in fact became assaultive. Tr. 65 at 88 (Gill).

J-365. For those patients who tested staff by refusing medication, May Unit staff had no argument to demonstrate to patients that they were really serious in telling patients they needed their medications. Tr. 58 at 34 (Seil).

J-366. Betty Bybel, for example, suffered following the issuance of the temporary restraining order because the staff felt unable to effectively impose limits and failed to act decisively. The temporary restraining order precluded the staff from making treatment and management decisions that conveyed to her that they were committed to a particular course of action and that that course of action was in her best interest. Tr. 65 at 103, 109-110 (Gill).

(e.) *Following the Issuance of The Temporary Restraining Order, There has been an Increase in the Numbers of Patients Transferred to Bridgewater State Hospital.*

J-367. The number of Austin Unit patients transferred to Bridgewater State Hospital increased since the issuance of the temporary restraining order. The number of patients transferred to Bridgewater prior to the restraining order was less than one per year. After the restraining order, the number transferred to Bridgewater increased to approximately five or six per year. Tr. 65 at 110, 111 (Gill).

J-368. The reason the number of patients transferred to Bridgewater State Hospital has increased since the issuance of the temporary restraining order is the fact that staff were uncertain *when* to forcibly medicate a patient. When not medicated sufficiently early or sufficiently forcefully, patients have tended to escalate. Patients who have been in a state of decompensation or psychotic turmoil escalate into situations of actual violence. Tr. 65 at 111 (Gill).

J-369. Following the issuance of the temporary restraining order, there was an increase in the number of patients

transferred to Bridgewater State Hospital from the May Unit and Solomon Carter Fuller Mental Health Center. Between January 1, 1973, through April 30, 1975, there were only five patients so transferred. Between May 1, 1975, through December 20, 1976, there were eleven patients so transferred. Tr. 58 at 42-43 (Seil).

J-370. The increase in the number of patients transferred to Bridgewater was caused by restrictions upon forcibly medicating patients as the result of the temporary restraining order. Specifically, the temporary restraining order caused a reluctance to medicate patients early enough in time to bring them under control. By the time the patient's escalation of behavior had continued to violence, justifying forcible medication, the patient was beyond the Unit's ability to treat him. Tr. 58 at 42-43 (Seil).

(f.) *The Temporary Restraining Order Has Had a Negative Impact on the Staffing of the Austin and May Units.*

J-371. Since the issuance of the temporary restraining order, staff turnover at the Austin Unit has increased quite extensively, from approximately 12 to 15 staff departures per year to 25 staff departures per year. Tr. 65 at 116, 117 (Gill).

J-372. Following the issuance of the temporary restraining order, the May Unit developed the reputation of being a hospital that was under restrictions in its ability to treat patients, and, as a result thereof, it was very difficult to attract staff. Tr. 58 at 33 (Seil).

J-373. Some staff members did not want to remain at the May Unit as they watched patients, whom they had cared for and who had done reasonably well on medications, deteriorate after refusing medications. Tr. 58 at 33 (Seil).

J-374. The issuance of the temporary restraining order affected the residency program at the Austin Unit. In 1978, two residents quit the program because of their concerns about the lawsuit. Tr. 65 at 122, 123 (Gill).

J-375. The issuance of the temporary restraining order contributed to the loss of the psychiatric residency program for the inpatient service of the Solomon Carter Fuller Mental Health Center when it was concluded that the inpatient service was too dangerous for a single resident to be assigned to a ward. Tr. 58 at 35 (Seil).

(g.) *Patients Have Not Benefitted as a Result of the Temporary Restraining Order.*

J-376. While defendants have presented much evidence regarding the negative consequences of the temporary restraining order's limiting forced and involuntary medication to situations constituting a serious threat of violence, plaintiffs have presented no evidence that anyone benefitted from this limitation on forced and involuntary medication.

J-377. No patient at the Austin Unit who was not involuntarily or forcibly medicated after the temporary restraining order, but whose situation constituted a psychiatric emergency, benefitted from their refusal to take that medication. Tr. 66 at 33 (Gill).

PR-THE EFFECTS OF THE TEMPORARY RESTRAINING ORDER HAVE BEEN EXAGGERATED BY THE DEFENDANTS. THE DEFENDANTS FAIL TO DEMONSTRATE A COMPELLING STATE INTEREST IN FORCIBLY OR INVOLUNTARILY MEDICATING PATIENTS IN NON-EMERGENCIES

PR-1.) The defendants basically rely on *DR. GILL* and *DR. SEIL* to prove their claim that the medication position of the TRO had a negative impact of their units. However, both of these defendants' testimony should be given little weight.

PR-2.) By the defendant *SEIL's* own admission most of the 'deleterious effects' caused by the TRO in the May Unit were caused by the defendants' own conduct. Dr. *SEIL* admitted that the defendants failed to read a copy of the TRO for at least a week after it was issued. He admitted that the staff panicked because of their misinterpretation of the TRO; they

believed that they were prohibited from medicating or secluding in all circumstances. As Dr. *SEIL* stated: "During this period, unfortunately it gave us a good chance to panic. Rumors fly very quickly in a hospital. The major fear of the day shift was that the order prohibited seclusion or forced medication at all. And this terrified the staff. They felt that they would then have no control over the aggressive and assaultive behavior that might result.

Once this was clarified, things calmed down in that respect somewhat, but the staff was pretty demoralized. They felt they had been trying to do the best they could under whatever circumstances and now they were being told that they were doing it all wrong.

They were very reluctant to intervene earlier in what they thought would be an escalating process of an aggressiveness for fear that by definition *the assault would actually have to occur before the person could be secluded,* for example. *I think that aspect of it is what simmered down."* (Emphasis added.)

Of more concern was the medication issue. There (sic) was right after the TRO, a great many patients began refusing the medication, testing their right to do so, some of them to a great disadvantage. Most patients would do this more than they had before, but eventually when they found out from the staff, yes, you don't have to take your medication, if you don't want, the next they would or the next day they would. However there were a core of patients who decided to stay off medication. (J319, J332, J359, J360, J361) (D-*SEIL* Tr. 58-32, 33.) PR-3.) *DR. SEIL,* in his answers to interrogatory No. 14 in the 3rd set of interrogatories, dated from the period of May 1, 1975 to May 1977, stated that eight patients constituted the core of patients who refused medication for a 'prolonged period.' (J332) (D-*SEIL* 58-88, lines 19-25; 58-89, lines 1-12) PR-4.) *DR. SEIL* went on to declare that: There seemed to be an adversary relationship set up between patients and staff by the TRO, by the suit. Patients were afraid to intervene.

Staff were afraid to intervene with the patients for fear that the patients might take this to mean they were trampling on their rights, the rights of patients.

Patients, many of them, who had paranoid ideas already, began to distress the staff a great deal.

Again, these situations quieted down in time. (D-*SEIL* Tr. 58-33) (Emphasis added).

PR-5.) The number of admissions to the May Unit since the end of April 1975 has been between 600-800 patients a year with 40-70 patients in the hospital in any given time. (D-*SEIL* Tr. 58-85, lines 19-25; 58-86, lines 1-3.)

PR-6.) *DR. SEIL* wrote an affidavit in support of the motion to dissolve the temporary restraining order stating that approximately 10 percent of all the patients in his unit refused medication after the TRO for prolonged periods. (D-*SEIL* Tr. 58-86.)

PR-7.) DR. SEIL admitted that in response to plaintiffs' interrogatory No. 14 of the third set of interrogatories he based his answers on his personal observations of patients, his interpretation of their records and statements made to him by the staff. (D-*SEIL* Tr. 58-86, lines 10-19.)

PR-8.) *DR. SEIL* admitted he was very unhappy with the TRO and particularly the medication portion of the TRO. (D-*SEIL* Tr. 58-87, lines 21-25.)

PR-9.) *DR. SEIL* admitted he wanted the TRO dissolved. (D-SEIL Tr. 58-88, line 1-2.)

PR-10.) *DR. SEIL* and the staff at the May Unit closely monitored patients after the TRO. (D-*SEIL* Tr. 58-88, lines 11-18.)

PR-11.) Yet, Dr. *SEIL* listed only eight patients who refused their medication for prolonged period out of the approximately 1,200-1,600 patients admitted to the May Unit from May 1, 1975 to May 17, 1977. (D-*SEIL* Tr. 58-88, lines 19-25; 58-89, lines 1-12.)

PR-12.) One of those eight patients, Dr. *SEIL* mentioned

was the name plaintiff Ruby Rogers, who according to Dr. *SEIL* refused her medication in June 1975 and was in a deteriorated state, hostile, and unmanageable during this period. Yet during this same period, Ruby Rogers had a serious ulcer, which Dr. *SEIL* admitted can be extremely painful. In addition Ruby Rogers was vomiting and nauseous from the ulcer and was eventually sent to Shattuck Hospital to treat the ulcer. Dr. *SEIL* agreed that the ulcer did not result from her refusal of antipsychotic medication. (J-341) (D-*SEIL* Tr. 58-90, 91, 92.)

PR-13.) At the trial Dr. *SEIL* testified that during the period of refusal Ruby was assaultive on two occasions, yet in his answer to interrogatories, signed on November 17, 1977, Dr. *SEIL* stated he did not recall her being violent during the period of refusal in June and July, 1975. In addition he admitted he did not review Ruby Rogers records since he prepared his answers to the 3rd set of interrogatories. (J-341) (D-*SEIL* Tr. 58-93-95.)

PR-14.) When confronted with this descrepancy, Dr. *SEIL* claimed he meant she refused and was assaultive twice in May 1975, yet he failed to mention in the interrogatory that she refused in May as the interrogatory required. (J-341) (D-*SEIL* Tr. 58-95.)

PR-15.) After returning from the Shattuck Hospital, Ruby Rogers voluntarily agreed to take medication even though she was not required to take the medication. She stated she was looking for a medication that would not cause serious side effects that had bothered her in the past. (J-341) (D-*SEIL* Tr. 58-96, 97.)

PR-16.) Even though Ruby Rogers had refused Haldol and had consistently complained of the effects of Haldol prior to the TRO, it was not until after the TRO that the doctors at the May Unit respected her refusal. (J-341, J-376) (D-*SEIL* Tr. 58-92, lines 22-24 58-96; 58-97, line 1.)

PR-17.) Patient #1, was one of eight patients Dr. *SEIL*

stated in his response to interrogatory #14 who refused for a prolonged period after the TRO. This patient refused from June 11, 1976 to June 17, 1976. There is no indication this patient deteriorated during the period of refusal. In fact, Dr. *SEIL* admitted that six days would not be a long enough time for a patient to deteriorate. (D-*SEIL* Tr. 58-97, 98.)

PR-18.) The second patient he mentioned in the interrogatory is patient M.S. She is an elderly patient in her late 60's who had come to the hospital after being burned out of her home. She refused from August 8 to the end of September and from November 4 to November 12, 1975. The only time she was assaultive during her hospitalization was on October 23, 1975 which was not during the period M.S. was refusing medication. M.S. was never assaultive during her periods of refusal. (J-354) (D-*SEIL* Tr. 58-98, 99.)

PR-19.) Even with medication prior to the TRO M.S. had two delusions; her home still existed and the other one was she owned the hospital and it was her home and that she ran it. As a result she didn't want to be placed in a nursing home.

PR-20.) After the TRO and after refusing medication M.S. began to stay in bed all day. After a while staff believed this action may effect the condition of her skin because of her age; it might break it down and was therefore medicated involuntarily and was placed in a nursing home. (D-*SEIL* Tr. 58-50, 51)

PR-21.) The only time P.B., patient #3 ever had to be forcibly restrained at all during her entire admission was on March 28, 1976, in which she was forcibly escorted. This however, was not during a period of her refusal since the dates of refusal were March 4 to March 19, 1976. (J-344, J-350) (D-*SEIL* Tr. 58-99, 100.)

PR-22.) The patient P.B. was treated involuntarily after a court order to treat her was granted. It took four weeks to obtain this court order. Obtaining the court order did not take any substantial amount of staff time. (J-344, J-350, J-378) (D-*SEIL* Tr. 58-47-49)

PR-23.) The patient #4, C.T. was a patient who had been institutionalized for many years and was a voluntary patient who the May Unit discharged after his continued refusal. (J-338) (D-*SEIL* Tr. 58-101, 102.)

PR-24.) The patient A.H., patient #5 was a woman in her 40's who was a fashion designer. She had been hospitalized twice a year for the past seven years. A.H. was not refusing her medication in June 1975 which was the most difficult period of her hospitalization. (J-351) (D-*SEIL* Tr. 58-103, 58-52, lines 17-25.)

PR-25.) A.H. would not take her medication when outside the hospital, deteriorated and returned to the hospital voluntarily. Prior to the TRO she was forcibly medicated in non-emergencies. After the TRO she was admitted and she refused her medication but was not assaultive. Her behavior and hygiene deteriorated. She was forcibly medicated because other patients were assaulting her; because she was verbally abusive to others. It would take patient A.H. a month to six weeks without medication before she would deteriorate. (J-351) (D—*SEIL* TR. 58-53, 54; 58-56, lines 4-7.)

PR-26.) Dr. *SEIL* also testified about the patient G.J. She was on medication prior to the TRO. Dr. *SEIL* admitted she was occasionally assaultive when on medication prior to the TRO. Dr. *SEIL* did not do a study to determine if G.J. was more assaultive when she was on medication than during the period of her refusal. (J-319, J-337) (D—*SEIL* TR. 58-104.)

PR-27.) In fact, Dr. *SEIL* specifically stated that he didn't study the number of occasions G.J. was assaultive while on medication and during periods of refusal because "there were other variables to that." (J-319, J-337) (D—*SEIL* TR. 58-104, lines 15-18.)

PR-28.) Dr. *SEIL* then admitted there are a number of variables to consider in determining the cause of a patient's assaultiveness. He agreed that staff changes, and a number of other factors can influence behavior. Dr. *SEIL* agreed that

without controlling these factors one would not know the direct cause of a change in behavior, whether it was the lack of medication *or one of the numerous other factors influencing behavior.* (J-319, J-337) (D—*SEIL* TR. 58-104, 105, 106.)

PR-29.) Dr. *SEIL* admitted that if one was to make "an educated guess" about the cause of the change in behavior one would have to study a patient's behavior for a long period of time. (J-319, J-337) (D—*SEIL* TR. 58-106, lines 6-13.)

PR-30.) Dr. *SEIL* admitted that he didn't recall if G.J. was receiving medication prior to the TRO nor did he make a prolonged study of her. (J-319, J-337) (D—*SEIL* TR. 58-106, lines 14-19.)

PR-31.) Yet, Dr. *SEIL* testified in his direct examination that he "believes she could have been forcibly medicated" prior to the TRO to avoid problems in the hospital and legal problems outside the hospital even though he agreed she was not actually dangerous to herself or to others. (J-319, J-337) (D—*SEIL* TR. 58-43,44.)

PR-32.) The hospital was able to obtain a guardian for the patient G.M. who was admitted on an emergency 10 day paper by her husband, but who refused medication within a week after filing for a guardianship. (J-353, J-358) (D—*SEIL* TR. 58-57-59, particularly; 58-59, lines 17-19.)

PR-33.) Dorothy Cox testified that one patient, W.R. was deleteriously effected by the TRO. However, she admitted that the staff obtained a guardian (the patient's mother) within a month of seeking a guardian. She admitted that they sought a guardian because the doctors believed W.R. could not make his own treatment decision. (J-352) (D—Cox TR. 69-17.)

PR-34.) The testimony of Dr. *GILL* concerning the deleterious effects of the temporary restraining order should be disregarded or given little weight.

PR-35.) Dr. *GILL's* answer to interrogatory #14 of the 3rd set of interrogatories directly contradicts his testimony at trial.

(J-320, J-331) (D—*GILL* TR. 68-34, 35, 36, 37, 38, 39, 40.) (See also review of interrogatories which demonstrate that Dr. *GILL* was not giving a cross section of patients. He included patients who were hospitalized and discharged during the entire two year year period, May 1975 to June 1977.)

36.) Interrogatory #14 required Dr. *GILL* to supply the following information for every patient who refused their medication for prolonged periods from May 1, 1975 to June 23, 1977:

a.) The patient's initials.

b.) The patient's in-patient legal status (conditional, voluntary, on 10 day paper, held pending a court commitment hearing, held after being court committed, held for observation on criminal charges) at the time of the refusal. (Include more than one if applicable.)

c.) The dates the patient was an in-patient in your unit.

d.) *The length of time the patient refused his/her medication.*

e.) *The date(s) of refusal.*

f.) The type, and amount of medication refused.

g.) Whether the patient voluntarily assented to take the refused medication or an appropriate alternative at some point subsequent to their refusal.

h.) The patient's asserted reasons for his/her refusal.

i.) Whether the staff considered the patient competent or incompetent to make such a decision.

j.) Whether the patient was determined to be competent or incompetent in their most recent prior periodic review.

k.) Whether the staff filed a guardianship petition if the staff determined the patient was incompetent to make the decision.

l.) Whether the staff considered the refused medication as essential to the patient's treatment.

m.) *Whether the patient's mental or physical condition improved, remained the same or deteriorated during the period of the refusal.*

n.) *The extent to which the patient's mental or physical condition improved or deteriorated if at all, during the period of the refusal.*

o.) Detail the mental and physical condition of the patient prior to, during the period of, and subsequent to the period of refusal.

p.) *The number and type of violent acts committed by the patient prior to, during the period of, and subsequent to the period of refusal.*

q.) *The number and times the patient was forcibly or involuntarily medicated because of an emergency situation prior to, during the period of, and subsequent to the period of refusal.*

r.) *Whether the patient was transferred to another hospital or Bridgewater State Hospital during the period of the refusal (include the name of the hospital, if transferred).*

s.) Whether the patient was discharged as a result of their refusal to accept the prescribed medication.

PR-37.) The Austin Unit admitted approximately 500 patients a year, or 1,000 patients for a two year period. (D—*GILL* TR. 63-104.)

PR-38.) Dr. *GILL* required staff after the temporary restraining order to carefully document all involuntary interventions. (D—*GILL* TR. 68-31, lines 14-25; 68-32.)

PR-39.) Dr. *GILL* opposed the restraining order and therefore carefully scrutinized the potential or actual effect the order had on the Austin Unit.

PR-40.) Dr. *GILL* also testified he followed very closely the effect the TRO had on the patients in his Unit. (D—*GILL* TR. 68-32, lines 22-25; 68-33, lines 1-6.)

PR-41.) In his answer to interogatory #14 Dr. *GILL* listed only twelve patients who refused their medication for prolonged periods for the period of May 1, 1975 to June 23, 1977 — or 12 patients out of 1,000 patients admitted to the Austin Unit in that two year period. (Plaintiff's Exhibit #28; D—*GILL* TR. 63-104.)

PR-42.) The first patient Dr. *GILL* listed was patient #7. Patient #7 was a patient from August 26, 1975 to at least April 10, 1976. Patient #7's only time period of refusal was August 26th and August 27th 1975. The interrogatory indicates that patient #7 was violent on five occasions in August, none of which was during the two days patient #1 refused medication. There was no mental or physical deterioration when patient #7 refused medication, nor was the patient given intramuscular injection of medication, in an emergency during the period of the patient's refusal, nor was the patient transferred to Bridgewater. (Plaintiffs' Exhibit #28.)

PR-43.) Patient #8 was a patient from August 18, 1975 until October 3, 1975. There was no indication patient #8 refused at all. Assuming however, the patient was not taking medication from September 15th to September 24th 1975, there was no physical deterioration, nor was the patient assaultive to self or others during the period of refusal. In addition the staff did not need to involuntarily intervene in any emergency. In addition this patient was not transferred to Bridgewater. (Plaintiffs' Exhibit #28.)

PR-44.) In patient #9's first admission on August 7, 1975 there was no indication of any period of refusal of antipsychotics or lithium, only that the patient eventually accepted lithium treatment. Patient #9 was "violent at times" but there was no indication if that was during the period of refusal or while taking medication, or when the patient was both on and off medication. Patient #9 did not physically deteriorate, nor did the patient need staff to intervene with a chemical restraint in an emergency. The patient was not transferred to

Bridgewater. The patient was placed on extended visit on September 17, 1975. Patient #9's second admission began on December 31, 1975 and continued to August 17, 1976. This patient was not violent to self or others during any period of this admission. There is no physical deterioration, nor was there a need for involuntary emergency intervention. This patient was not transferred to Bridgewater. (Plaintiffs' Exhibit #23.)

PR-45.) Patient #10, G.E., was admitted to the Austin Unit on September 4, 1975. The patient was "out of control during his refusal period from November 1, 1975 to November 6, 1975. Yet #10 was discharged by the Austin Unit on November 6, 1975. Patient #10 was not violent, and did not physically or mentally deteriorate during the period of refusal. Involuntary emergency intervention was not necessary, nor was a transfer to Bridgewater. (Plaintiffs' Exhibit #28.)

PR-46.) Patient #11, G.G., was first admitted on April 17, 1975. He was discharged on April 26, 1975. He refused medication during his admission, yet he was not violent, nor did he physically or mentally deteriorate during this period of refusal. No involuntary intervention was necessary nor was a transfer to Bridgewater. (Plaintiffs' Exhibit #28.)

PR-47.) Patient #11 was readmitted on May 14, 1975. During his admission the staff believed he was unable to care for himself and was a serious threat to others during both his period of refusal as well as during the period he was on medication. This patient refused medication from May 14, 1975 to June 18, 1975, The patient was discharged on June 30, 1975. He was not transferred to Bridgewater nor was involuntary emergency interventions necessary. There was no physical or mental deterioration during his period of refusal. Patient #11 was readmitted on January 9, 1976. There is no period of refusal indicated during this admission. He was discharged October 1, 1976. Patient #11 was readmitted on October 1, 1976, the day he was discharged. He was again discharged on October 10, 1976. There is no indication #11 refused medica-

tion during the admission, yet was "very agitating, threatening and uncooperative." Patient #11's had other admissions in 1976 and 1977. He did not refuse drugs during these periods but dangerous behavior periodically reoccurred. Patient #11 was never transferred to Bridgewater. (J-343) (Plaintiffs' Exhibit #28.)

PR-48.) Patient #12 was admitted to the Austin Unit on January 6, 1975 and was an inpatient through June 30, 1975. He was discharged on February 18, 1975, but after decompensating was returned to the Austin Unit by police on March 18, 1975. Patient #12 did not refuse during this period. The only periods of refusal for patient #12 was the last week of November 1975, after his readmission on September 10, 1975, and intermittently in February 1976 (Stelazine). The patient was assaultive on many occasions while on medication. There was no violent acts committed during his November period of refusal. In addition there was no need for involuntary emergency intervention. During February he was occasionally assaultive. This patient was not transferred to Bridgewater. (Plaintiffs' Exhibit #28.)

PR-49.) Patient #13 was admitted on September 12, 1975. He remained a patient until at least November 3, 1976. During periods of refusal and during periods when accepting medication this patient was assaultive. However during periods of refusal the patient did not mentally or physically deteriorate. This patient was not transferred to Bridgewater. (Plaintiffs' Exhibit #28.)

PR-50.) Patient #14 was admitted to the Austin Unit on November 1, 1975. This patient was discharged and readmitted periodically until at least February 6, 1976. This patient was assaultive during November, when the patient was not refusing medication. He was also "very difficult and disruptive" during this period. Patient was also assaultive in January and February during a period of refusal. This patient did not mentally or physically deteriorate while refusing medication

and was not transferred to Bridgewater. (Plaintiffs' Exhibit #28.)

PR-51.) J.T., Patient #15, was admitted on October 25, 1975. There is not indication of the period in which this patient refused medication. However it could be interpreted that he refused or was not taking medication in November. This patient was assaultive in November. Beginning December 19, 1975, the patient was taking medication without resistance." As of April 14, 1976 #15 was taking medication and was "less assaultive." This patient did not physically or mentally deteriorate during the period of refusal. He was not transferred to Bridgewater. (Plaintiffs' Exhibit #28.)

PR-52.) Patient #16, was admitted to the Austin Unit on January 7, 1975, discharged on June 30, 1975 and readmitted on July 9, 1975. He was again admitted on March 9, 1977 and placed on extended visit on March 18, 1977. This patient refused medication (Navane 10 mg) for the period of three months after admission on July 9, 1975. Patient #16 was not violent during the period of refusal nor did the patient require an involuntary emergency intervention. The patient did not physically or mentally deteriorate when off drugs but failed to improve. The patient was not transferred to Bridgewater. (Plaintiffs' Exhibit #28.)

PR-53.) Patient #17 was admitted to the Austin Unit on October 12, 1978. This patient refused medication until October 19th, 1976. On or about October 20th the patient agreed to accept medication (Chlorpromazine). During the period of refusal patient #17 was threatening and on one occasion assaultive. However the patient displayed "a gradual increase in threatening behavior" *while on medication*. The patient was also assaultive during the period the patient was taking medication. This patient was discharged on April 17, 1977. The patient did not mentally or physically deteriorate during the period of refusal, in fact worsened while on medication. The patient was not transferred to Bridgewater. (Plaintiffs' Exihibit #28.)

PR-54.) Patient #18, James Colleran, was a patient in the Austin Unit since November 1973. He asserted reason for refusal was that medication made him groggy. During periods of refusal he would mentally deteriorate, however "some deterioration would often precede the refusal." There was no physical deterioration, though the patient may have lost weight. When accepting medication he would continue to harbor negative feelings about the medication. He was not violent during periods of refusal. He was not transferred to Bridgewater nor was he discharged because of refusing drugs. (Plaintiffs' Exhibit #28.)

PR-54a.) Throughout this lawsuit, both in attempting to dissolve the TRO and at trial, Dr. *GILL* and *SEIL* have alleged that the medication portion of the TRO has had a substantial negative impact on patient care and caused severe harm to patients. Interrogatory #14 required the defendants to prove their contention through facts, not their biased impressions. Interrogatory #14 required the defendants to demonstrate for each patient who refused medication for a prolonged period The alleged negative effect of providing patients the right to refuse in non-emergencies. The defendants responses were based on their review of medical records of their Units and not their impressions. As Dr. *GILL* stated "I am a person who doesn't particularly believe in quantification." The interrogatory required that the defendants compare each patient's behavior and mental and physical states during periods of refusal and during periods the patients were receiving medication. The responses to this interrogatory are the only detailed comparison study provided this court of patients with and without medication. It was prepared by the defendants. Yet the responses to the interrogatory directly contradicts the defendants impressions. The responses demonstrate that there is no basis in fact for the defendant contention that there has been serious negative ramifications of the TRO. (J-356, J-331, J-319, J-357, J-358, J-364) (D—*GILL* TR. 68-30, line 1-15.)

PR-55.) The defendants response to interrogatory #14

demonstrate that the defendant can not and have not proven that:

a.) Patients are more assaultive or dangerous when on medication then when off medication and that there is a causal relationship between refusal and increase in violence on the part of patients refusing medication.

b) Most patients will seriously physically or mentally deteriorate during periods of refusal. The interrogatories prove that in fact some patients deteriorate while on medication.

c.) The use of involuntary emergency interventions increased during periods patients were off medication.

d.) The increase in Bridgewater transfers had any relationship to those patients who refused medication for prolonged periods. (J-367, J-368, J-369, J-370).

PR-56.) At trial, Dr. *GILL* claimed that 89 patients from May 1, 1975 to the summer of 1977 refused antipsychotics and suffered serious physical or mental consequences as a result of their refusal for a least a significant number of days. This testimony is based on the same period covered by Dr. *GILL's* response to interrogatory #14. (J-331) (D—*GILL* TR. 66-70, 68-34 lines 20-24) (Plaintiffs' Exhibit #28.)

PR-57.) In addition Dr. *GILL* testified that 56 patients at the Austin Unit refused medication and had their hospitalization prolonged, though they did not suffer serious physical or mental consequences as the result of their refusal. This testimony is based on the same period covered by Dr. *GILL's* response to interrogatory #14. (J-346) (D—*GILL* TR. 66-70, 71)

PR-58.) His testimony should be disregarded or given little weight for the following reasons:

a.) First of all these claims directly contradicts Dr. *GILL's* responses to plaintiffs' Interrogatory #14 of the 3rd set of Interrogatories, as set out.

b.) Secondly patient #7, who Dr. *GILL* claimed refused for a prolonged period refused medication for only two days. Since Dr. *GILL* included this patient as one of the patients who refused for a prolonged period, a reasonable conclusion is that Dr. *GILL* believed that two days of refusal was a prolonged period. Therefore assuming all patients who refused for two or more days were included in Dr. *GILL's* response to interrogatory #14, the patients Dr. *GILL* state deteriorated must have refused medication for less than two days. Yet Dr. *SEIL* admitted that even six days of refusing medication would not be a long enough period of time for a patient to deteriorate. (D—*SEIL* TR. 58-97, 98.)

c.) Thirdly, the 145 patients records were made available to plaintiffs counsel for one day, during the period Dr. *GILL* was completing direct examination and beginning cross. Though a search of all these records were impossible given the number and size of the records, a summary of some of these records were introduced to the court, and were considered as evidence by the court. These measures again demonstrate that the defendant *GILL's* testimony should be given little weight. (TR. 68-50 lines 18-21)

1.) PM was admitted November 1977 through August 1978. There is no R's indicating any refusal in the medication and treatment record during this entire period. He was violent occasionally, but he was on medication. They discontinued lithium because it did not manage his violence, not because of any refusal. He was transferred to Bridgewater. (TR. 68-48)

2.) Patient AMH was hospitalized June 1975. She was 19 years old. It indicates no R's in the medication and treatment record for antipsychotic medication. It indicates no violence in the charts.

The January 1976 core evaluation indicates that her condition was improved. The periodic review on 9/15/75 indicates that her condition was improved. (TR. 68-48)

3.) Patient EP, was admitted 12/4/75 and discharged 10/9/76. There is not indication of any violence, any seclusion at all during this period of time. On 9/23/76, the patient was released and she was improved. There were no R's on the medication and treatment records. (TR 68-49)

4.) Patient No. 4 is ML. It states on the involuntary intervention sheets for ML for 9/21/76 through 2/77, "no involuntary intervention." On the involuntary intervention sheets, it is stated from dates 2/15/78 there was "no involuntary interventions."

In her psychological evaluation, her treatment plan, it states: "Improved."

On 2/23/77 a progress note states: "ML is doing well."

The only indication of any violence, violence to self or others was on March 25, 1976, when she was secluded. However she was on medication and there was no refusal.

On 7/9/78, she was self-destructive and she had just come on the ward and was given an intramuscular injection at that time. She was discharged six days later on 7/15/78.

They used medication during those periods before her discharge. (TR. 68-49)

5.) Patient No. 5, MW, was admitted for nine days. She had no history of mental illness. The documents state she never took meds nor was it required. (That's in the treatment plan of MW.) There was no seclusion, no violence, and no transfer to Bridgewater. (TR. 68-50)

6.) WS was an elderly patient. He was in the unit twice. There is no indication of refusal on the record. No violence, no indication of any mental or physical deterioration on the records. (TR. 68-50)

7.) DT was in the unit for eight years, was given an IM, Haldol, in the beginnning of his stay. There was no medication or treatment record. There was no seclusion, no violence, and no indication of physical or mental deterioration. (TR. 68-50)

PR-59.) In addition, even the defendants expert agreed that the medication portion of the T.R.O. had a positive effect on statewide psychiatric practice. Dr. Myerson declared:

> "When this mode of treatment was challenged and brought under question, *I think that we in the state hospitals in psychiatry and perhaps other areas of psychiatry too, not with bad results,* were forced to look at our practices and take into consideration the problems of whether it was really indicated to continue the treatment against a person's will or whether the person had some right to refuse." (Emphasis added).

(J0372) (D—Myerson TR. 63-71 lines 6-13)

PR-60.) Dr. *GILL* admitted under examination by the court that he and the medical profession "choked on the problem, yes" when deciding not to forcibly medicate J.T. after a

violent act; admitting his indecision about forcibly medicating resulted in a subsequent violent act. (J-335, J-355) (D—*GILL* TR. 65-98, 99, 100)

PR-61.) Dr. *KANTAR* admitted the difference in his practice after the TRO it made him think about it 'much more.' The outstanding example of a patient Dr. *KANTAR* would have forcibly medicated prior to the TRO but was prohibited to after the TRO was a woman who believed medication was poison. She was an involuntary patient who ate, she wasn't bleeding, "she was warm," "she was cared for," she wasn't punching anybody, she wasn't bothering anybody, she was thriving, but refused medication. According to Dr. *KANTAR* she needed to be forcibly medicated because "in the community she wouldn't survive" and it was their job to get patients back into the community. (D—*KANTAR* TR. 11-160-170).

PR-63.) Doctors should be permitted to forcibly or involuntarily medicate only when there is an emergency; the serious threat of or as a result of extreme violence, personal injury or attempted suicide. (J-394, J-399, J-403, 404, 405).

(I.) *A Requirement to Obtain A Guardian Whenever A Patient Needs to be Forcibly or Involuntarily Medicated Is Unworkable, Impractical and Anti-Therapeutic*

J-378. Even in an emergency situation, it can take a few days and, more likely, a matter of three, four, five weeks, in the probate court to get a guardian. It can take years if contested. Tr. 51 at 19 (Olin).

J-379. It has taken as long as eight months to get a guardian for patients refusing medication after the temporary restraining order. Tr. 66 at 68 (Gill).

J-380. It has taken as long as three months to get a guardian even when a family member has been willing to serve. Tr. 65 at 83-84 (Gill).

J-381. Approximately 2 to 3 patients leave the hospital per day without authority. This increases the seriousness of the consequences of any delay in treatment caused by the seeking of a guardian. Tr. 65 at 84 (Gill).

J-382. There are not enough people available to become guardians. Tr. 65 at 80 (Gill).

J-383. With a majority of patients, incompetence is not a static condition. Having a guardian appointed for about a week is a major effort to accomplish very little, with the concommitant risk, in fact, of alienating the patient. Tr. 65 at 80 (Gill).

J-384. Emotional disturbance, in many instances is a transitory phenomenon. It is better to allow an individual after he clears to maintain his own responsibility rather than have it turned over to a guardian. Tr. 51 at 20 (Olin).

J-385. The Department of Mental Health has been unable to find guardians for all the retarded patients in need of them. Tr. 65 at 81-82 (Gill).

J-386. It is very difficult to obtain guardians for an individual when there is not a family member available who is willing to act as a guardian, particularly given the fact that state hospital patients are usually poverty stricken and unattractive people. Tr. 65 at 82 (Gill).

J-387. Approximately one-half the patients at the Austin Unit do not have families or have families that have been uninvolved with the patient for a matter of years. Tr. 65 at 82-83 (Gill).

J-388. The act of seeking a guardian to a fairly major extent destroys the effort of having the patient participate actively in his own treatment. Tr. 65 at 79 (Gill).

J-389. Obtaining guardians has interfered with the hospital's treatment alliance with a patient, when the patient has played the guardian off against the staff. Tr. 65 at 84-85 (Gill).

J-390. Patients at times resent the appointment of family members as guardians, as part of the patient's problems are related to their dealings with the family member. See Tr. 58 at 56-60 (Seil) and Tr. 65 at 102-103 (Gill) for case histories with this problem. Patients have felt that the staff is siding with

their family against them, and this has hurt the treatment alliance. On other occasions, appointment of a family member has been countertherapeutic as the patient's need was to build independence from his family. Tr. 65 at 85-86, 102 (Gill).

J-391. Guardians may be more interested in conserving money and keeping the patient in the hospital than permitting the patient to use his or her funds to live outside the hospital. Tr. 51 at 42 (Olin).

J-392. Guardians tend to be unavailable when a treatment decision needs to be made. TR. 65 at 80-81 (Gill).

J. *The Implications of Allowing Patients to Refuse Treatment — Summarized*

J-393. The temporary restraining order and the history of antipsychotic medications in mental hospitals demonstrate that allowing patients to refuse antipsychotic medication will (1) increase the use of restraints and seclusion, (2) increase hospital populations, (3) increase the length of stay in mental hospitals for patients refusing medication, (4) decrease voluntary admissions, (5) negatively affect the milieu of the entire hospital, (6) exacerbate the ambivalence of psychotic patients, (7) cause unnecessary severe psychic suffering, (8) increase chronicity, (9) lead to warehousing of patients, (10) lead to increased transfers to maximum security facilities, (11) lead to an increased use of guardians in untherapeutic circumstances, (12) lead to increased violence on the hospital wards, (13) lead to patients who need treatment being denied hospitalization, and (14) lead to problems in keeping and hiring staff to work at state hospitals.

K. *Forcible Medication — Proposed Standards*

J-394. Doctors should be able to forcibly medicate when a patient requires the prompt initiation of treatment to prevent further severe suffering by that patient or the rapid worsening of that person's clinical state. Tr. 66 at 6-7 (Gill).

J-395. Doctors should be permitted to forcibly medicate in their clinical judgment all patients at state hospitals, as they

would not be at the state hospital absent serious illness. In their clinical judgment, doctors should not always forcibly medicate the patient. Tr. 66 at 64-66 (Gill).

J-395A. Doctors should be allowed to forcibly medicate when patients are under conditions of a psychiatric emergency. Tr. 665 at 111-112 (Gill).

J-396. Doctors should be allowed to forcibly medicate patients whose psychiatric state grossly interferes with their general functioning. Tr. 66 at 63-64 (Gill).

J-397. Doctors should be allowed to forcibly medicate patients in a state of psychotic turmoil, characterized by an inability to function or a great deal of distress, pain, or anxiety. Tr. 65 at 112 (Gill).

J-398. Doctors ought to be able to forcibly medicate for an emergency psychiatric condition to prevent, amont other things, the possibility of the patient's condition developing into a violent one. Tr. 66 at 25-26, 60-61 (Gill).

J-399. The standard for forcibly medicating a patient should not be tied to the standard for secluding a patient. Seclusion and forced medication are of an entirely different order and different types of intervention.

Forcible medication is a treatment for a psychiatric condition that may include the patient's refusing that treatment because they're not able to acknowledge that they are ill.

Seclusion is used to control violence or attempted suicide or personal injury.

While seclusion may be a prelude to treatment, medication is a treatment in itself. Tr. 66 at 29-32 (Gill).

J-400. Forcible medication should be allowed when the medication is critical to the patient's well-being or the well-being of others. Tr. 51 at 109 (Olin).

J-401. A psychiatric patient who does not understand what he is refusing should not have the right to refuse treatment. Tr. 51 at 33 (Olin).

J-402. Patients should be forcibly medicated when heading for a complete relapse. Tr. 57 at 100 (Brill).

J-403. It is sound medical practice to forcibly medicate a patient who is acutely psychotic and in a critical psychiatric state even when that patient's present behavior does not constitute a serious threat of personal injury, but the failure to medicate the patient more probably than not will lead to the patient's further deterioration and the probability that down the road, someone will be physically hurt. Tr. 61 at 33 (Brill).

J-404. It is sound medical practice to forcibly medicate a patient who is acutely psychotic, in severe mental anguish, even when that patient's present behavior does not constitute a serious threat of personal injury, when the failure to medicate the patient more probably than not will lead to that patient's further deterioration which may or may not result in someone getting physically injured. Tr. 61 at 33-34 (Brill).

J-405. It is sound medical practice to forcibly medicate a patient who is acutely psychotic, even when that patient's present behavior does not constitute a serious threat of personal injury, when that patient has not responded to nonpharmacological treatment and when the patient in the past has responded so favorably to the receipt of medication as to be releasable from the hospital in a short period of time after taking the medication. Tr. 61 at 34 (Brill).

B. *Informed Consent—The Involuntary Patient*

J-411. It was acceptable medical practice from January, 1973, through April, 1975, to prescribe medication without seeking a guardian for an involuntary patient who was willingly accepting the medication even though the doctor believed that the patient was not capable of making rational decisions regarding his treatment. Tr. 52 at 52-53 (deMarneffe); Tr. 51 at 28 (Olin). The decision had already been made by the court that such patients were in need of care and treatment. Tr. 52 at 52-53 (deMarneffe).

C. *Informed Consent—The Voluntary Patient*

J-412. It was acceptable medical practice from January, 1973, through April, 1975, to allow psychiatric patients to sign a consent form for voluntary admission to the hospital, (1) without first making an independent determination as to the competence of the patient signing the consent form and (2) when the doctor did not believe the patient was capable of making rational decisions as to his or her specific need for treatment. Tr. 52 at 51-52, 63-65 (deMarneffe; Tr. 51 at 18-20, 23 (Olin).

J-413. It was acceptable medical practice from January, 1973, through April, 1975 to prescribe medication without seeking a guardian for an involuntary patient who was willingly accepting the medication, even though the doctor believed that the patient was not capable of making rational decisions regarding his or her treatment. Tr. 51 at 24 (Olin).

(IX.) *MEDICATION*

(A.) *General Procedures*

K-196. Patients' medications at the Austin Unit were reviewed regularly on an ongoing basis by the entire staff in rounds, team meetings, staff meetings, and on an impromptu basis whenever an issue surrounding a patient's medication arose. Tr. 39 at 71 (Herschel).

K-197. If a patient complained to a staff member about her or his medication, that complaint was discussed with a doctor, as well as other staff members. Tr. 39 at 71 (Herschel); Tr. 63 at 144-146 (Gill).

K-198. Staff at the Austin Unit met regularly to discuss patients' treatment: at rounds five days a week, at team meetings twice weekly, at staff meetings, and at privilege meetings with staff and patients once a week. Tr. 39 at 71 (Herschel).

K-199. Patients at the Austin Unit met with staff, including the ward physician, once a week in order to discuss the efficacy and side effects of each patient's medication. At these meetings, patients have requested to have their medication

stopped or increased. Tr. 39 at 71, 72, 74 (Herschel); Tr. 63 at 144-146 (Gill).

K-200. If a patient at the Austin Unit was refusing regular medication on a regular basis, that fact would be reported to his or her physician. Tr. 39 at 70 (Herschel).

K-201. Doctors at the Austin Unit were notified if a patient was actually forcibly medicated. Tr. 64 at 58 (Gill).

K-202. It was the policy and practice at the May Unit that patients' medications were reviewed regularly by their physicians at the weekly administrative meetings and the team meetings on each of the wards. Tr. 60 at 81, 82 (Kahn).

K-203. Team meetings of staff and patients were held on each ward twice a week, and the details of the side effects of drugs were reviewed at these meetings. Tr. 60 at 82 (Kahn).

K-204. The circumstances under which a physician's order authorizing involuntary medication of a patient was to be instituted were reviewed by the physician with the staff. Tr. 61 at 69, 70 (Burke-Green).

K-205. It was the policy at the May Unit that the physicians were to be notified when a patient refused medication. Tr. 61 at 53 (Burke-Green).

K-206. If a patient were in fact involuntarily medicated, a doctor would know about it. Tr. 61 at 70 (Burke-Green).

K-207. Patients were forcibly medicated only on a doctor's orders. Tr. 61 at 68 (Burke-Green).

K-208. Where there was a standing I.M. PRN order in the patient's chart and the patient refused oral PRN medication, it was the routine practice at the May Unit to notify the patient's physician or the physician in charge that the patient received I.M. PRN medication. Tr. 61 at 55 (Burke-Green).

(B.) *Medication PRN Orders*

K—209. Prior to administering PRN medication, it was the practice at the Austin Unit for a staff member to talk to the patient to determine why he or she was agitated and, at times, to take the patient to a quiet, less stimulating portion of the ward. Tr. 41 at 4 (Crane).

K-210. Nursing staff were trained to give out medications. The nurses were more than competent. They were very good people, for the most part. Tr. 63 at 120 (Gill).

K-211. The May Unit nurses who were given discretion to administer PRN medications were qualified to do so. Tr. 60 at 148 (Kahn); Tr. 58 ar 8-9 (Seil).

K-212. The licensed nurses at the May Unit were very familiar with the patients there. Some had worked with the same patients for 10 or 15 years. They knew them well, their needs and what signs and behaviors they would exhibit that would lead to further difficulties. Tr. 58 at 9 (Seil).

K-213. With the type of staff found at state hospitals, it was acceptable medical practice from January 1, 1973, through April 30, 1975, to issue PRN orders for antipsychotic medication. Tr. 57 at 77-80 (Brill).

K-214. It was acceptable medical practice from January 1, 1973, through April, 1975, to leave to the discretion of a nurse the decision whether to administer PRN medication. Tr. 52 at 69 (deMarneffe); Tr. 57 at 80 (Brill).

K-215. It is commonplace for staff members to have discretion to administer PRN orders for antipsychotic medication. Tr. 31 at 65 (Messinger).

K-216. The nurse is a trained professional, familiar with and trained in the giving of medication. Tr. 52 at 69 (deMarneffe).

K-217. A psychiatric nurse is a person who is trained in the observation of symptoms and reactions to medication. Tr. 52 at 69 (deMarneffe).

K-218. It was acceptable medical practice from January, 1973, through April, 1975, to write a P.O. or IM PRN medication order for an antipsychotic drug. Tr. 57 at 80 (Brill).

K-219. The administration of frequent PRN medications is good medical practice, as it indicates that the orders have been set up to meet needs as they arise. Tr. 53 at 90-93 (Gair).

K-220. There is no evidence that the use of PRN medication caused any damage to any of the named plaintiffs.

(C.) *The Use of Antipsychotic Medication as a Restraint*

K-221. The involuntary or forcible medication of a patient is usually not a restraint, and, is, thus, not subject to the restrictions of M.G.L. c. 123, §21.

K-222. The Austin Unit did not use antipsychotic medication as a restraint. Tr. 64 at 62 (Gill).

K-223. There were no standing orders for chemical restraints. Tr. 11 at 116. (Kantar).

K-224. PRN orders were not used for chemical restraints. Tr. 11 at 118 (Kantar).

K-225. Medication given in therapeutic doses is not using medication as a restraint. Tr. 64 at 61-62 (Gill).

K-226. The use of medication as a chemical restraint is very rare. Tr. 62 at 18 (Kahn).

K-227. Antipsychotic medication is not a chemical restraint, because unless used in dangerously high doses, the patient is always able to wake up, move around by himself, and is not anesthetized. Tr. 57 at 134 (Brill).

K-228. Properly adjusted dosage and combinations of modern drugs rarely cloud consciousness, except perhaps briefly while the individual optimum dose is sought. Tr. 64 at 63 (Colodny and Kurlander, "Psychopharmacology as a Treatment Adjunct for the Mentally Retarded, Problems and Issues, in Memolascino, F. *Psychiatric Approaches to Mental Retardation*, p. 372).

K-229. Antipsychotic medications are not chemical restraints. If it were chemical restraint that doctors were using or that had been used in the hospitals, doctors would have long since been quite satisfied with the barbiturates and the other heavy sedatives which are in truth chemical restraint and put people to sleep. Tr. 57 at 81-82 (Brill).

* * *

3. DEFENDANTS' REBUTTAL OF ANTICIPATED PLAINTIFFS' REBUTTAL

Dr. Gill testified that at least 159 patients suffered negative consequences from the issuance of the temporary restraining order. Tr. 66 at 70-71 (Gill).

Plaintiffs' counsel tried to establish:

(1) When Dr. Gill answered Question 14 in Plaintiffs' Third Set of Interrogatories, he remembered fewer patients who had refused medication and suffered negative consequences. Tr. 68 at 35-45 (Gill);

(2) The records of patients about whom Dr. Gill testified did not support his testimony that they suffered from refusing medication. Tr. 68 at 47-50 (Gill).

In fact:

(1) At the time Dr. Gill answered the questions in the Third Set of Interrogatories, he had not sat down and reviewed a list of all patient admissions, discussing that list with other staff to jog his memory as to who had been negatively impacted by the temporary restraining order. Tr. 68 at 109 (Gill). At the time of testimony, he had done so. Tr. 66 at 70 (Gill); Tr. 68 at 33-34 (Gill).

(2) Plaintiffs' counsel presented records of only seven of the 159 patients Dr. Gill testified had suffered negative consequences as a result of the temporary restraining order, Tr. 66 at 70-71 (Gill); Tr. 68 at 47-50 (Gill), despite the fact that defendants made available to plaintiffs the records of all 89 patients who Dr. Gill testified suffered serious physical or mental negative consequences because they refused medication after the temporary restraining order.

(3) Records for those patients that Dr. Gill mentioned by name on the witness stand support his testimony that they suffered harm by refusing medication. Defendants' Exhibits W, X, and Y. See Tr. 66 at 67-69 (Gill).

D. ELIZABETH BYBEL

1. *Plaintiffs' Proposed Findings of Fact and Defendants' Rebuttal**

ELIZABETH BYBEL'S BIOLOGICAL AND MEDICAL BACKGROUND

1.) Elizabeth Bybel was 32 years of age, in January, 1973. (P—*BYBEL* TR. 39-7, lines 1-3.)

2.) She has five children. (P—*BYBEL* TR. 39-7, lines 11-12.)

3.) She graduated from Weymouth High School in 1958. (P—*BYBEL* TR. 39-8, lines 6-7.)

4.) She was employed first with the I.R.S. as a secretary starting back in 1958, she later worked at the Army Base, quit in 1960 because she was pregnant. She also worked as a waitress. (P—*BYBEL* TR. 39-8, lines 9-25.)

5.) The first time she was a patient at the Austin Unit was January, 1973. She was taken to ward 6 on the third floor of the Austin Unit. Later, that ward changed to ward A-3, and 4, in 1975. (P—*BYBEL* TR. 39-9, lines 6-21.)

6.) Doctor Kantar, Gill and Schildkrout were all her doctors. (P—*BYBEL* TR. 39-10, lines 6-11.)

7.) Her therapist was Layne Erban, now Mrs. Herschel. (P—*BYBEL* TR. 39-11, lines 22-24.)

8.) The following summary shows the admission status of Elizabeth Bybel in the Austin Unit from January 3, 1973 to April 30, 1975.

a. On January 3, 1973 she was admitted by court order pursuant to M.G.L. c. 123, §15(b) for determination of her competency and trial for the voluntary use of intoxicating liquor, being drunk. That Court order consisted of two twenty-day observation period orders. EX 3021

b. On February 2, 1973, she escaped. EX 3020

c. On February 10, 1973, the Austin Unit discharged her administratively. EX 3020

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* Defendants' Rebuttals are designated "DR"

d. On March 10, 1973, she returned and was readmitted on a "conditional voluntary" status pursuant to M.G.L. c. 123, §§10, 11. EX 3040

e. On March 10, 1973, she returned and was readmitted on a "conditional voluntary" status. EX 3039

f. On March 15, 1973, she escaped. EX 3048

g. On March 26, 1973, she was administratively placed on "extended visit." EX 3039

h. On April 12, 1973, she returned and was readmitted on a "conditional voluntary" status. EX 3039

i. On April 30, 1973, she left and was placed on "extended visit." EX 3039

j. On May 19, 1973, she returned and was readmitted on a "conditional voluntary" status. EX 3039

k. On June 4, 1973, the Austin Unit petitioned the district court for her commitment and held her in the hospital pending a commitment hearing, pursuant to M.G.L. c. 123, §6. EX 3056

l. On June 5, 1973, she escaped. EX 3039.

m. On June 25, 1973, she returned to await the commitment hearing. EX 3039

n. On July 3, 1973, she escaped. EX 3039

o. On July 6, 1973, she was committed by the district court for a period of six months to end January 5, 1974. EX 3078

p. On July 30, 1973, she returned to the unit.

q. On August 15, 1973, she escaped. EX 3039

r. On August 27, 1973, she returned.

s. On September 6, 1973, she escaped. EX 3039

t. On September 7, 1973, she returned. EX 3039

u. On September 15, 1973, she escaped. EX 3039

v. On October 1, 1973, she returned. EX 3039

w. On October 12, 1973, she escaped. EX 3039

x. On November 27,1973, she returned. Ex 3039

y. On November 29, 1973, she escaped. EX 3039

z. On December 3, 1973, she returned. EX 3039

aa. On December 24, 1973, she was discharged by the unit for a home visit. EX 3039

bb. On December 25, 1973, she returned. EX 3039

cc. On January 5, 1974, she was discharged completely from the Austin Unit. EX 3039

dd. On January 20, 1974, she was returned to the unit on a ten-day emergency commitment order pursuant to M.G.L. c. 123, §12. EX 30204

ee. On January 24, 1974, she signed a "conditional voluntary." EX 30205

ff. On January 30, 1974, the Austin Unit filed a new commitment petition and held her pending a hearing on that petition. EX 30207

gg. On February 15, 1974, she was discharged for a home visit. EX 30204

hh. On February 22, 1974, she was discharged for a home visit. EX 30202

jj. On February 24, 1974, she returned. EX 30202

kk. On March 8, 1974, she was discharged for a home visit. EX 30202

ll. On March 11, 1974, she returned. EX 30202

mm. On March 17, 1974, she was discharged for a home visit. EX 30202

nn. On March 18, 1974, she returned. EX 30202

oo. On March 22, 1974, she was discharged for a visit. EX 30202

pp. On March 25, 1974, she returned. EX 30202

qq. On March 25, 1974, she was away from the unit without permission. EX 30202

rr. On March 26, 1974, she returned. EX 30202

ss. On March 29, 1974, she was discharged for a visit. EX 30202

tt. On March 31, 1974, she returned. EX 30202

uu. On April 2, 1974, she was discharged from the hospital completely. EX 30202

vv. On April 20, 1974, she returned on a "conditional voluntary" status. EX 30295

ww. On April 21, 1974, she left the unit without permission. EX 30295

xx. On April 22, 1974, she returned. EX 30295

yy. On May 14, 1974, she escaped. EX 30239.

zz. On May 16, 1974, the unit filed a new commitment petition. EX 30305

aaa. On July 9, 1974, after a hearing before the local district court, in which the commitment petition was denied, she was officially discharged from the hospital. EX 30295, 30309, 30311

bbb. On November 4, 1974, she returned on a ten-day emergency commitment order. EX 30243

ccc. On November 4, 1974, she signed a "conditional voluntary" paper. Ex 30258

ddd. On November 15, 1974, she escaped. EX 30258

eee. On November 19, 1974, she was discharged for a home visit. EX 30258

fff. On November 19, 1974, she was returned to the unit on a ten-day emergency commitment paper. EX 30247, 30258

ggg. On January 10, 1975, the hospital filed a new commitment petition and held her pending a hearing on that petition. EX 30250

hhh. On January 18, 1975, she left the unit without permission. Ex 30258

iii. On January 29, 1975, she returned. EX 30281, EX 30258

jjj. On March 18, 1975, she returned.

kkk. On March 21, 1975, she escaped. EX 30258

lll. On March 24, 1975, she returned. EX 30258

(Stipulations for Elizabeth Bybel, page A34 - A38.)

9.) Elizabeth Bybel was diagnosed as a Manic Depressive by Austin Unit staff from January 1973 until at least April 30, 1975. Ex 3018, 30263.

She was also diagnosed at various times by Austin Unit staff as "reaction depression", EX 3039, 3029; "acute and chronic schizophrenic", EX 3085; "borderline personality" 3-1, 3-6; "hysteric character disorder" 3-3, 3-11; "psychotic" 3-52, 3-45; "grossly psychotic" 3-29; "manic depressive" 3-24, 3-28, 3-30, 3-39, 3-41, 3-46, 3-51, 3-55, 3-56, 3-57, 3-58, 3-59, 3-72, 3-76, 3-78; "reactive depression" 3-41. (Stipulations for Elizabeth Bybel, page A38.)

DR-9.) See Defendants' Proposed Finding D-4. Betty Bybel was not diagnosed by the Austin Unit staff as "borderline personality" or "hysteric character disorder;" those diagnoses were made by staff at the Medfield State Hospital in December, 1972. Pl. Ex. 9, Doc. Nos. 300001, 300006, 300003, 300011.

10.) Dr. Schildkrout's diagnosis of Elizabeth Bybel was that she was schizo-affective, and that that was always his diagnosis of her. (D—*SCHILDKROUT* TR. 44-24, lines 8-11.)

11.) Dr. Schildkrout took issue with the diagnosis of her being a manic-depressive, said that there were behaviors that she exhibited that were not consistent with the diagnosis of manic-depressive. There had always been some disagreement about her diagnosis. (D—*SCHILDKROUT* TR. 44-24, lines 16-25.)

12.) Dr. Schildkrout does not remember putting the diagnosis of schizo-affective into Mrs. Bybel's record, (D—*SCHILDKROUT* TR. 44-25, lines 2-4.)

15.) She was in an intense and severe depression from the end of March through May, 1975, while in seclusion. (D—*SCHILDKROUT* TR. 44-35, lines 2-16.)

DR-15.) See Defendants' Proposed Findings D-127, D-128. Dr. Schildkrout did *not* testify that Betty Bybel was in an intense and severe depression from the end of March through May, 1975. His testimony was: "Toward the end of that period, she did go into a depression, yes." Tr. 44 at 35 (Schildkrout).

16.) Elizabeth Bybel was an outspoken person with a strong personality who questioned a lot of decisions that were made about her treatment and also the treatment of other patients. She had a protective kind of attitude towards a lot of the other patients and seemed concerned about them as well as about her own situation. She could also be very insulting at times, she could get on people's nerves. (P—Franceen TR. 20-44, lines 5-12.)

17.) Mrs. Bybel was very panicky at times, very restless and intrusive into other people's affairs, very difficult to establish some kind of authority with and at other times she would be depressed and withdrawn. Then at other times she could be very even and concerned about other patient's welfare and communicative with the staff. (P—Golder TR. 7-20, lines 7-13.)

18.) "She had great difficulty asserting herself. That was her whole trouble." (D—*GILL* TR. 65-62, lines 20-25; 65-63, line 1.)

DR-18.) See Defendants' Proposed Finding D-186.

19.) There were certain repetitive psychological themes in her care which were rather well delineated and revolved around the issue of loss of inter-personal relationships which would include relatives and therapists. (P—Messinger TR. 31-102, lines 8-22. D—*SCHILDKROUT* TR. 44-32, lines 24-25; 44-33, lines 1-6.)

20.) Loss played a factor in some of her decompensation in the past.D—*SCHILDKROUT* TR. 44-33, lines 11-13.)

21.) She was very sensitive to feelings of being abandoned by people. (D—*SCHILDKROUT* TR. 44-33, lines 14-17.)

22.) The temporary loss of Mrs. Bybel's therapist often caused an exacerbation of many of her symptoms. (P—Messinger TR. 31-103, lines 1-12.)

23.) When Mrs. Bybel was in distress, either anxious or depressed, she turned to people and used them and often took their loss or departure as an abandonment and a reawakening of a painful experience of loss and death from earlier in her life. (P—Messinger TR. 31-103, lines 13-21.)

24.) Elizabeth Bybel's brother Dennis died in January of 1974. That had been a very difficult time for her because her family really didn't want her to sit with them. (D—Herschel TR. 39-86, lines 15-21.)

25.) During April 1974, Mrs. Bybel was admitted surrounding the time when she had stolen some mail. (D—Herschel TR. 39-90, lines 1-3.)

26.) As of January 1973, the probable prognosis was that Elizabeth Bybel would tend to recover over a period of time. (D—Myerson TR. 62-73, lines 6-13.)

DR-26-27.) See defendants' Proposed Findings D-289-D-296.

27.) It is very hard to tell the degree of improvement for Elizabeth Bybel between '73 and '75 from the records. There seemed to be improvement, but it would wax and wane, he said. (D—Myerson TR. 62-69, lines 21-24.)

28.) Elizabeth Bybel was not deteriorating. She had a very chronic long-standing manic illness. This was without signs of deterioration, however. (D—Myerson TR. 62-72, lines 8-14.)

DR-28.) Dr. Myerson went on to testify that "she started with basically zero; and it's hard to say whether she is getting better or worse during this period of time.... She was...one of the most seriously manic people I have ever heard of. And constituted one of the most difficult therapeutic problems." Tr. 62 at 72, 73 (Myerson).

29.) In Dr. Schildkrout's opinion, her prognosis was very grave, quite grave. "she had a long history of psychotic illness." (D—*SCHILDKROUT* TR. 43-63, lines 9-14.)

(II.) *ELIZABETH BYBEL'S MEDICATION MALPRACTICE AND ASSAULT AND BATTERY CLAIMS AGAINST THE DEFENDANTS GILL, KANTAR, AND SCHILDKROUT*

THE INVOLUNTARY USE OF MEDICATION BY THE DEFENDANTS UPON THE PLAINTIFF ELIZABETH BYBEL WAS NOT PRIVILEGED SINCE IT WAS USED WITHOUT HER CONSENT ON OCCASIONS WHERE AN EMERGENCY AS DEFINED BY M.G.L. C. 123, §21 DID NOT EXIST.

(A.) *The Austin Unit As a Matter Of General Practice Medicated Its Patients In Non-Emergency Situations For Many Reasons Other than Restraining Seriously Out-Of-Control Behavior.*

170.) According to Dr. Myerson, if Elizabeth Bybel had been forcibly medicated in a situation where there was not an occurrence or threat of violence, that was standard procedure. The nurses would first try to persuade the patient to take medication, and then if the patient would refuse, they would give it to them without their consent. (D—Myerson-TR. 62-65, lines 10-14.)

DR-170). Dr. Myerson testified that this involuntary medication was standard procedure with a seriously disturbed patient such as Betty Bybel when the Chief and staff concluded that the patient constituted a psychiatric emergency and the medication was needed to control the emergency. Tr. 62 at 65, 66 (Myerson).

(B.) *Elizabeth Bybel Was Medicated Involuntarily and Without Her Informed Consent by the Defendants in Non-emergencies.*

196.) Dr. *KANTAR* felt that prior to the temporary restraining order, Elizabeth Bybel was not able to make rational treat-

ment decisions about her own life. (D—*KANTAR*—TR. 12, 126, 127, lines 12-25, 1-2.)

DR-196, 198.) Dr. Kantar was only able to state that Betty Bybel was unable to make rational decisions from January, 1975-April, 1975. During this period, he believes she was an involuntary patient. Tr. 12 at 130 (Kantar).

197.) Nevertheless, Dr. KANTAR ordered or authorized the medication of Elizabeth Bybel in non-emergency situations without seeking a guardian for her. (D—*KANTAR*—TR. 12-127, lines 3-11.)

DR-197.) Dr. Kantar also testified that he never observed nor was he aware of Betty Bybel being involuntarily medicated in situations where there was not the occurrence of or serious threat of personal injury, extreme violence or attempted suicide. Tr. 48 at 11 (Kantar). As Dr. Kantar explained in his Response to Plaintiffs' Second Request for Admissions, Responses 7 and 10, this did not mean that Betty could not refuse the medication authorized.

198.) During this period of time in which Dr. *KANTAR* did not feel that Elizabeth Bybel was able to make rational decisions about her life, her legal status within the hospital as an inpatient kept changing. (D—*KANTAR*—TR. 12-127-129, lines, 18-25, 1-25, 1-10.)

199.) The Austin Unit permitted Elizabeth Bybel to sign an Application for Care on a Conditional Voluntary Basis on six occasions. (Stipulation of Elizabeth *BYBEL*)

200.) The following documents indicate that Elizabeth *BYBEL* was considered by the Austin Unit as competent. (Doc. Nos. 3037, 3040, 3050, 3052, 3060, 3061, 3974, 3077, 30202, 30218, 30297, 30242.)

201.) Elizabeth Bybel on many occasions refused to consent to her medications. (D—*KANTAR*—TR. 14-20, lines 4-7.)

202.) Between January 1, 1973 and April 30, 1975, Elizabeth Bybel was involuntarily medicated with the authorization of the following defendants on at least the following dates with the following medication:

a) January 15-24, 1973, Dr. *GILL* as supervisor of Dr. Eisenstadt. Thorazine, (Doc. Nos. 3033, 3034, 3035.)

b) April 19-26, 1973, Dr. *GILL* as supervisor of Dr. Eisenstadt, Thorazine IM. (Doc. Nos. 3083, 30134, 3084.)

c) January 15-24, 1973. Dr. *GILL* as supervisor of Dr. Eisenstadt, Thorazine. (Doc. Nos. 3033, 3034, 3055.)

d) July 31-August 15, 1973. Dr. *SZYLK*. Thorazine (Doc. Nos. 3088, 30146, 3087.)

e) August 4-15, 1973. Dr. *GILL* as supervisor of Dr. Horowitz. Haldol. (Doc. No. 3088.)

f) August 30-September 15, 1973. Dr. *GILL* as supervisor of Dr. Whaley. Haldol. (Doc. Nos. 3089, 3085, 30144, 30146, 30147.)

g) October 2-11, 1973, Dr. *GILL* as supervisor of Dr. Whaley, Haldol. (Doc. Nos. 3091, 3092, 30192.)

h) January 20-31, 1974, Dr. *GILL* as supervisor of Dr. Whaley, Haldol concentrate. (Doc. Nos. 30221, 30223, 30698.)

i) March 13-20, 1974. Dr. *GILL* as supervisor of Dr. Whaley, Thorazine. (Doc. Nos. 30226, 30701, 30227.)

j) April 20-May 22, 1974, Dr. *GILL* as supervisor of Dr. Whaley. Thorazine. (Doc. Nos. 30312 to 30314, 30703, 30702, 30315, 30316, 30306, 30317, 30708.)

k) February 1 to 3, 5 to 8, 1975. Dr. *SCHILDKRAUT*, Haldol. (Doc. Nos. 30714, 30283.)

l) March 18 to 24, 1975. Dr. *SCHILDKRAUT*, Navone. (Doc. Nos. 30284, 30285, 30715.)

DR-202.) The physicians' orders and medication and treatment records cited in this proposed finding *do not* support the contention that Betty Bybel was involuntarily medicated.

(a) While Document No. 300033 indicated an order for Thorazine, p.o. or i.m. if refuses, as Betty Bybel's regular medication as of January 15, 1973, this order was discontinued on January 24, 1973. Betty Bybel received *no* intramuscular

antipsychotic medication in January, 1973. (Document No. 300034). The presence of "p.o. or i.m." order does not support the contention that Betty Bybel took against her will the oral Thorazine which she received between January 15 and January 24, 1973. (The Document No. 300035 is not relevant to the time period cited.)

(b) (Documents Nos. 300083 and 300084 are not relevant to the time period cited.) While Document No. 300081 indicates that Dr. Eisenstadt ordered p.o. or i.m. Thorazine as Betty Bybel's regular medication, this order was discontinued on April 26, 1973. (Doc. No. 300082) (Document No. 300134 is not relevant to the time period cited.) Betty Bybel refused her regular Thorazine at 8 a.m. on April 19, 1973, and did not receive it. On April 20, 1973, at 8 a.m. she did not receive regular Thorazine. On April 23, 1973, at 4 p.m., her regular Thorazine was held and she did not receive it. (Document No. 300101, Betty Bybel's medication and treatment record for April, 1973.) The information cited by plaintiffs does not support the contention that Betty Bybel took against her will the oral Thorazine which she received between April 19 and April 26, 1973.

(c) See Defendants' Response to Plaintiffs' Proposed Finding No. 202(a), above.

(d)&(e) Between July 31 and August 15, 1973, Betty Bybel's medication orders included no i.m. order for regular medication. While Document No. 300087 indicates that Dr. Szlyk signed an admission order at 8 p.m. on July 30, 1973, that order was discontinued by Dr. Horowitz' order of July 31, 1973, which *did not* include an i.m. order for regular Thorazine if Betty Bybel refused p.o. Thorazine. (Doc. Nos. 300087, 300088). On August 2, 1973, Dr. Horowitz changed Betty Bybel's order for regular Thorazine, but again did not include any i.m. order. On August 3, Dr. Horowitz discontinued her previous regular Thorazine order and ordered Haldol twice a day and Thorazine at hour of sleep, but did not

include an i.m. order for these regular medications. On August 4, 1973, Dr. Horowitz ordered that if Betty Bybel refused the oral Haldol he had prescribed, she could receive oral Thorazine. (Doc. No. 300088) Betty Bybel did not receive any regular medication intramuscularly on July 30 or 31, 1973, (Doc. No. 300135) or from August 1 through August 15, 1973 (Doc. No. 300146A, medication and treatment record for August, 1973). Her regular Thorazine was held on August 3, 1973, at 4 p.m. and 8 p.m., and she did not receive these two doses. She refused her regular Haldol at 8 a.m. on August 4, 1973, and did not receive it. (Doc. No. 300146A, medication and treatment record for August, 1973).

(f) While Document No. 300089 indicates that Dr. Whaley ordered Haldol, p.o. or i.m. if refuses on August 30, 1973, this order was discontinued on September 3, 1973, and a new order written for Betty Bybel's regular medication which did *not* include an i.m. order. (Doc. Nos. 300089, 300147B) Betty Bybel escaped and was not in the hospital for parts of September 6 and 7, 1973. (Plaintiffs' Proposed Finding No. 8). She refused her Haldol on September 14, 1973, at 4 p.m. and 8 p.m., and these refusals were honored (Doc. No. 300147B). The information cited by plaintiffs does not support the contention that Betty Bybel took against her will the oral antipsychotic medication she received between August 30 and September 3, 1973.

(g) Betty Bybel escaped from the hospital on September 15, 1973, and was readmitted on October 1, 1973. (Plaintiffs' Proposed Finding No. 8). While Document No. 300091 indicates no order by Dr. Whaley, it does indicate a "p.o. or i.m." order for Haldol by Dr. Horowitz. Between October 2 and 11, 1973, Betty Bybel also required dressing of a wound on her right leg, warm saline soaks, and ampillicin; a pregnancy test was ordered. (Doc. No. 300092; see Defendants' Proposed Findings D-61-D-68). Betty Bybel was returned to the Austin Unit by police on October 1, 1973, after purchasing a boat for

$2,500. Doc. No. 300064. On the ward she became verbally abusive, hostile, and assaultive. She had a cut on her foot which became infected and swollen. Doc. No. 300065A. (Document No. 300192 is not relevant to the time period here.) The information cited by plaintiffs' does not support the contention that Betty Bybel took against her will the oral antipsychotic medication she received between October 2 and 11, 1973.

(h) As of January 20. 1974, there is no "p.o. or i.m." order for regular medication for Betty Bybel (Doc. No. 300221), although Doc. No. 300223 indicates Dr. Whaley did write such an order on January 25 and 28, 1974. Betty refused her regular medication on January 25 and 28, 1974, at hour of sleep, and these refusals were honored; in addition, her regular medication was held and she did not receive it at 4 p.m. on January 30 and 31, 1974. (Doc. No. 300698). When Betty Bybel was admitted to the Austin Unit, she was unable to control herself. (Document No. 300203.) See Defendants' Proposed Finding D-69. The information cited by plaintiffs does not support the contention that Betty Bybel took against her will the oral medication she received between January 20 and 31, 1974.

(i) While Document No. 300226 indicates an order for "p.o. or i.m." Thorazine on March 13, 1974, that order was discontinued on March 19, and there was no i.m. order for regular medication instituted. (Doc. No. 300226) (Document No. 300227 has no relevance to this time period). Betty Bybel did not receive Thorazine intramuscularly between March 13 and 20, 1974. Her regular Thorazine was held and she did not receive it at 8 a.m. on March 14, 1974, at 4 p.m. and hour of sleep on March 17, 1974. The information cited by plaintiffs does not support the contention that Betty Bybel took against her will the oral medication she received between March 13 and 20, 1974.

(j) See Defendants' Proposed Findings D-109, D-110, D-112. While Document No. 300312 does not indicate any medication order on April 20, 1974, by Dr. Whaley, Document Nos. 300313-300315 do indicate medication orders by Dr. Whaley. Betty Bybel refused her regular Thorazine at 8 a.m. on April 21, 1974, and this refusal was honored. On April 28, 1974, she did not receive her regular Thorazine at hour of sleep. Between April 24 and 30, 1974, she did not receive her medication intramuscularly (Doc. Nos. 300703, 300703A). Between May 1 and May 22, 1974, she did not receive her medication intramuscularly. On May 1, 1974, she did not receive her regular Thorazine at hour of sleep; she did not receive her regular Thorazine at 4 p.m. on May 14, 1974, and at noon on May 17, 1974. (Doc. No. 300704). The information cited by plaintiff does not support the contention that Betty Bybel took against her will the oral antipsychotic medication she received between April 20 and May 22, 1974.

(k) On February 5, 1975, Betty Bybel returned from AWA very psychotic, delusional, and agitated. She claimed to have been raped, as well as being an FBI agent. Between February 5 and February 7, 1975, she was extremely belligerent, hitting, biting staff, screaming and punching wildly. At least for part of this time, she refused p.o. medication and needed almost continuous seclusion for protection of herself, staff and other patients. Because of this behavior, the staff were unable to get a gynecological exam done or a proper medical workup. Doc. No. 300259A, 300259B.

Betty Bybel's medication orders included no order for intramuscular medication between February 1 and 3, 1975. (Doc. Nos. 300282, 300283, 300714). On February 5, 1975, she received Haldol i.m., stat., on her admission. (Doc. Nos. 300283, 300714). Between February 6 and 8, 1975, she received no intramuscular medication. On February 3, 1975, she refused her regular Haldol at hour of sleep, and this refusal was honored. She did not receive her regular Haldol at hour of

sleep on February 5, 1975. (Doc. No. 300714,) (1) Betty Bybel escaped from the Austin Unit on March 21, 1975, and was returned on March 24, 1975. Plaintiffs' Proposed Finding No. 8. When Betty Bybel was admitted on March 18, 1975, there was an order for i.m. medication stat, upon admission, but her orders for regular medication did not include an i.m. order. This initial order was changed that same day by Dr. Schildkrout, who instituted an order for Navane as regular medications. This order for regular Navane did *not* include an i.m. order. (Doc. No. 200284). As her medication and treatment record confirms, there was no i.m. order for regular medications for Betty Bybel between March 18 and March 24, 1975. (Doc. No. 300715) The confrontation cited by plaintiffs does not support the contention that she took against her will the regular oral medication she received between March 18 and March 21, 1975.

203.) If Elizabeth Bybel received medication involuntarily, she received that medication as treatment rather than as a restraint. (D—*KANTAR*—TR. 14-36, lines 18-21.)

DR-203.) See Defendants' Proposed Findings D-324, D-325.

204.) Elizabeth Bybel may have attempted to organize other patients to resist staff. (D—*KANTAR*—TR. 14-37, lines 7-10.)

DR-204.) However, Dr. Kantar was not aware of Betty Bybel attempting to organize other patients to resist staff. Tr. 14 at 37 (Kantar).

205.) Dr. Kantar assumed that if Elizabeth Bybel were approached with medication that she would fight more often than not. (D—*KANTAR*—TR. 14-46, lines 13-19.)

DR-205.) Dr. Kantar testified that Betty Bybel more often than not was fighting all the time. Tr. 14 at 46 (Kantar). He also testified that he did not know whether she fought with staff members who attempted to involuntarily medicate her. Tr. 14 at 40 (Kantar).

206.) There was a formal staff meeting to discuss the medication of Elizabeth Bybel in January of 1974 at which

nurses Bridget Herrin and Layne Erban were present. Ms. Erban being the nursing supervisor. At that meeting Layne Erban (who was leading it) said that Betty Bybel was a ringleader, that she challenged authority, that she questioned her treatment and caused the other patients to question their treatment and also caused the patients to question their medication and that this was something that had to be stopped, that the patients were questioning the medication. One way of stopping this was a treatment plan that they had devised that Ms. Erban would seclude Betty so that when she interfered with other patients or had them question their medication, she would be secluded. (P—Franceen—TR. 20-53, lines 11-21; 61, lines 18-19; 63, lines 15-18; P. Crumbly—TR. 71-27, 28, lines 15-18, 11-25.)

DR-206.) Layne Erban never stated that Betty Bybel was a ring-leader or that she was in any way urging other patients to go against the staff of the Austin Unit. Tr. 40 at 3 (Herschel).

Austin Unit staff never devised a treatment plan whereby Betty Bybel would be secluded when she urged patients to question their medication. Tr. 40 at 4 (Herschel).

Bridget Herron never stated that Betty Bybel was a ringleader who questioned her own treatment, as well as the treatment of other patients and that she should be secluded to stop this. Tr. 40 at 6 (Herschel).

Betty Bybel was not referred to by any staff member as a ringleader, (Tr. 65 at 76 [Gill], nor was it ever reported to Dr. Gill that a staff member had called Betty Bybel a ringleader. Tr. 65 at 77 (Gill).

Betty Bybel was not a ringleader; she was, for the most part, disliked by the majority of patients because of her intrusiveness, her yelling and screaming, and her stealing. Because of these behaviors, she was quite unpopular with other patients. Tr. 65 at 76, 77 (Gill).

John Crumbley did not testify as to any treatment plan proposed by Layne Herschel in this context. Tr. 71 at 27, 28 (Crumbley).

207.) In addition, they discussed how Betty Bybel had to receive her medication as well as all other patients who had regular medication. (P—Franceen—TR. 20-53, 54, lines 2-25, 1.)

DR-207.) Layne Erban never stated that Betty Bybel, as well as other patients for whom regular medication was prescribed, were required to take their medication. Tr. 40 at 5 (Herschel).

208.) There was already a seclusion treatment program for Elizabeth Bybel. Her treatment program was that if she expressed any kind of non-passive behavior such as becoming angry, expressing her anger, interfering with other patients by having them question their medication, she was to be secluded. This treatment plan was put into effect in the Fall of 1973. (P—Franceen—TR. 20-57, lines 12-23.)

Dr-208.) There was not a treatment plan for Betty Bybel whereby she was to be secluded when angry or when expressing anger. Tr. 40 at 108 (Herschel).

Betsy Franseen never saw Betty Bybel secluded pursuant to a treatment program, put into effect in the fall of 1973, whereby she was to be secluded for being angry or interfering with other patients by having them question their medication. Tr. 20 at 57, 58 (Franseen).

Betsy Franseen never saw Betty Bybel being secluded at all. Tr. 20 at 88 (Franseen).

209.) Many patients in the admissions room told him "you have to shut her up...", referring to Elizabeth Bybel. (D—*GILL*—TR. 65-70, lines 7-8.)

210.) She was supporting patients and advising them that they shouldn't take medication, for example; they should ask for the right to talk on the telephone and that they should ask for home visits, they should ask for more privileges; there were a number of things Betty asked people to do on the ward. (P—Crumbley—TR. 71-28, lines 20-25.)

DR-210.) Betty Bybel's behavior frightened other patients. She yelled and cursed at patients and yelled at staff members

that they were terrible and were trying to kill the patients. She created a massive frenzy in the whole ward which was frightening for her, as well as the patients and the staff. She stated that the reason the patients were frightened was that they were being mistreated and things were terrible, and this scared other patients. Tr. 43 at 60, 61 (Schildkrout).

211.) Elizabeth Bybel had influence over other patients. She was at times a leader of some patients. (P—Crumbley—TR. 71-29, lines 3-8.)

212.) The medication Mrs. Bybel received included thorazine, lithium and haldol given in both pill form and by concentrate. (P—Franceen—TR. 20-45, lines 17-21.)

213.) About 80% of the time in which Elizabeth Franceen observed Elizabeth Bybel being medicated, Mrs. Bybel would refuse her medication and then she would be threatened with a needle if she did not take the medication. (P—Franceen—TR. 20-45, lines 25, 1-3.)

214.) Of the time in which Ms. Franceen was an attendant Elizabeth Bybel was an in-patient approximately 90 days. She had an opportunity to observe Elizabeth Bybel medicated on approximately 180 occasions of which 80% of which occasions Mrs. Bybel refused her medication. (P—Franceen—TR. 20-47, lines 1-12; P—Carriello—TR. 22-7, 8, lines 24-25, 1-21.)

215.) Elizabeth Franceen observed Elizabeth Bybel being medicated in the late afternoon and evening five days a week while she was an attendant nurse at the Austin Unit. (P—Franceen—TR. 20-44, lines

216.) Elizabeth Bybel was medicated with a needle, in December or January, 1973 or 1974. (P—Carriello—TR. 22-10, 11, lines 16-24, 22-25.)

DR-216.) In December, 1973, Betty Bybel received no intramuscular medication. Pl. Ex. 7, Doc. No. 300192. When Betty was admitted to the Austin Unit on January 20, 1974, she was unable to control herself. Between that date and

January 30, 1974, when the Austin Unit petitioned for her commitment, she was psychotic, agitated, assaultive, and unable to manage herself. It was concluded that there was a strong likelihood of serious harm to the patient if she did not receive hospital treatment. Pl. Ex. 7, Doc. Nos. 300207, 300207A.

Neil Cariello was unable to state which physician may have authorized the incident of forced medication he observed. Tr. 22 at 48 (Cariello).

Nor was he able to state even an approximate date when it occurred. Tr. 22 at 10-12 (Cariello).

217.) Of the approximately 80% of the time that Elizabeth Bybel was seen refusing her medication she generally did not require that the medication be given through a needle but would accept it orally once threatened. (P—Franceen—TR. 20-48, lines 2-7.)

218.) Elizabeth Franceen observed Elizabeth Bybel receiving a needle when she refused medication between 5% and 10% of the time that she refused. (P—Franceen—TR. 20-48, lines 8-12.)

DR-218.) Betsy Franceen testified she only had a "vague recollection" of the number of times Betty Bybel was forcibly medicated. Tr. 20 at 48 (Franceen).

Betsy Franceen was unable to tie the instance of Betty Bybel being forcibly medicated to any physician. Tr. 20 at 88, 89 (Franceen).

The only time that Betsy Franceen specifically remembered Betty Bybel being forcibly medicated was in December of 1973, or in January of 1974. Tr. 20 at 49 (Franceen). See Defendants' Response to Plaintiffs' Proposed Finding No. 216, above.

219.) Elizabth Bybel would generally complain about being sick to her stomach on the drugs, of not being able to think clearly or feeling sluggish and that she just didn't like the taste of it. (P—Franceen—TR. 20-46, lines 6-9.)

220.) When Mrs. Bybel would be threatened with the medication by needle she would generally be defiant; she wouldn't be particularly acting in an exaggerated or outrageous way but, she would be defiant about not taking the medication, saying that she didn't need it. (P—Franceen—TR. 20-46, lines 10-16.)

DR-220.) This testimony standing alone does not provide sufficient information to determine whether Betty Bybel was in an emergency state. See Defendants' Proposed Findings J-65, J-68.

221.) A person could not be acutely psychotic who was calmly telling the physician that he liked him but disagreed with the decision to take the medication. (D—*GILL*—TR. 66-7, lines 6-12.)

222.) Elizabeth Bybel received PRN medication during the time in which Mr. Cariello was at the Austin Unit as determined by the staff present, which included the six attendant nurses and not regular nurses. (P—Cariello—TR. 22-13, 14, lines 13-25, 1.)

223.) Elizabeth Bybel would almost always initially refuse her medication. When she would refuse, she would generally be told, "Betty, if you don't take it orally we are going to give you an injection." (P—Cariello—TR. 22-8, lines 7-10.)

224.) Cariello remembers seeing Elizabeth Bybel refusing medication approximately 75% of the time. (P—Cariello—TR. 22-8, lines 19-21.)

225.) During the period in which Mrs. Bybel was refusing medication, she was usually carrying on about her business, sometimes sitting, sometimes laying, sometimes talking to other patients. (P—Cariello—TR. 22-8, 9, lines 24-25, 1.)

226.) When Elizabeth Bybel would refuse medication, generally the staff member would become more increasinly insistent that she would take her medication; she would then become more increasingly insistent that she would not. She was told that she would be given a needle if she didn't take it orally. (P—Cariello—TR. 22-9, 10, lines 22-25, 1.)

227.) Elizabeth Bybel was over-sedated. (P—Cariello—TR. 22-16, lines 24-25.)

DR-227-228.) Neil Cariello's testimony was admitted only for his perception of the situation and not as any medical conclusion that there was an excess of sedation administered to her, which would require expert testimony. Tr. 22 at 17 (Cariello).

228.) Elizabeth Bybel was very drowzy, sleeping a lot; her gait was impaired; she would not respond rapidly when being spoken to, her eyelids were drooping, she appeared to be over-medicated. (P—Cariello—TR. 22-17-lines 11-14.)

229.) There were conversation with Layne Erban, Elizabeth Bybel's administrator, regarding her treatment plan in the Spring of 1974. It was brought to Ms. Erban's attention the fact he thought Elizabeth Bybel was being over-medicated. Mrs. Bybel had been charged with stealing a bag of U.S. mail in March or April of 1974. When she returned to the Austin Unit the Unit implemented a seclusion and medication plan. She was secluded constantly for about a week and according to Layne Erban she was "snowed" with medication to over-medicate her in order to prevent her from escaping. (P—Cariello—TR. 22-17, 19, lines 15-22, 4-16.)

DR-229.) Layne Erban never stated in April or May of 1974, that Betty Bybel's medications were to be increased and that the staff would "snow" her by keeping her over-medicated. Tr. 40 at 6, 7 (Herschel).

Layne Erban did state in a meeting in April or May, 1974, following Betty Bybel's arrest by Federal authorities that Mrs. Bybel's activities leading up to her arrest were not a joke; that Mrs. Bybel was increasingly getting herself into more serious situations when she was outside the hospital; and that she needed to have an increase in medication to help her control some of these impulse-ridden activities. Tr. 40 at 6, 7 (Herschel).

Dr. Gill never heard any staff member state that Betty

Bybel should be "snowed with medication," or words to that effect. Tr. 65 at 77 (Gill).

230.) Mr. Cariello remembered Elizabeth Bybel receiving PRN medication ten times. (P—Cariello—TR. 22-15, lines 14-16.)

231.) "You have the right to be informed of the risk and possible side effects of treatment and to refuse treatment at any point." Mrs. Bybel was asked if that was an accurate description of her rights at the Austin Unit and her answer was "absolutely, positively no." (P—*BYBEL*—TR. 39-20, lines 15-21.)

232.) Ms. Byble was not informed that she had any rights. (P—*BYBEL*—TR. 39-21, line 6.)

233.) When she first saw that patients right form, she said that it was a farce, and that it was a lie. (P—*BYBEL*—TR. 39-22, 21, lines 10-15, 15-18.)

234.) She informed the doctors that she did not want her medications on many occasions. (P—*BYBEL*—TR. 39-22, lines 10-12.)

Franceen described in reference to Mrs. Bybel. (P—Messinger—TR. 32-37, 38, lines 25, 1-11.)

(C.) *The Defendants Medication Practices Regarding Elizabeth Bybel Constituted Unacceptable Medical Practice and Harmed Her.*

240.) The amount of medication Elizabeth Bybel was receiving in January, 1974 would account for the slow thinking, slurred speech and "generally zonked out" appearance, that witnesses Cariello and Franceen describe in reference to Mrs. Bybel. (P—Messinger—TR. 32-37, 38, lines 20-25, 1-11.)

DR-240.) Dr. Messinger was not able to testify that the slow thinking, slurred speech and "generally zonked out" appearance of Betty Bybel as described by Neil Cariello and Betsy Franseen was the result of the medication Betty Bybel was receiving in January, 1974; he was only able to answer "in a tentative fashion" because he needed to know "the time rela-

tionship between the administration of the medication and the dose and the appearance of those symptoms." He testified that he would like to know the specifics before committing himself. Tr. 32 at 37, 38 (Messinger).

243.) There would be no other circumstances which medication could be medically justified when given in an involuntary manner. The practice of the psychiatric residents who authorized the medication that was involuntarily given to Elizabeth Bybel during the period of January, 1973 to April, 1975 where she was not physically assaultive and she refused, fell below the standard of care of the average qualified psychiatric resident during that period. (P—Messinger—TR. 32-44, 45, lines 14-25, 1-4.)

244.) The practice of the psychiatric supervisors who oversaw the performance of the psychiatric residents who authorize medication for Elizabeth Bybel that was given involuntarily during January, 1973 to April, 1975 where she was not physically assaultive fell below the standard of care of the average qualified supervising psychiatrist during that period. (P—Messinger—32-46, lines 1-9.)

245.) Such medication practices have no therapeutic treatment value. It would be antithetical to treatment because treatment in psychiatry whether it's done verbally through psychotherapy or any other modality of treatment has to rest on a relationship of mutual respect and trust. (P—Messinger—TR. 32-45, lines 17-24.)

254.) In Dr. Myerson's opinion, Elizabeth Bybel's resistance to treatment was a substantial contributing factor to her failure to improve over this period. (D—Meyerson—TR. 62-70, lines 12-20.)

255.) In Dr. Myerson's opinion, Elizabeth Bybel probably would have been able to stay out of seclusion if she had taken her lithium during the period in question. (D—Meyerson—TR. 62-68, lines 13-21.)

256.) Elizabeth Bybel believed that lithium caused her to be somewhat depressed and in Dr. *GILL's* opinion was one of the issues that lead her to stop taking the lithium. (D—*GILL*—TR. 65-72, lines 18-20.)

257.) In Dr. *GILL's* opinion, Elizabeth Bybel's failure to improve from January, 1973 through April, 1975 was substantially caused by her resistance to treatment. (D—*GILL*—TR. 65-74, lines 4-11.)

258.) "Betty Bybel was highly resistant to treatment." (D—*GILL*—TR. 65-69, line 7.)

259.) Her condition did improve somewhat when she used the lithium during the period of '73, '74, '75. (D—Myerson—TR. 62-67, lines 14-19.)

260.) The medication was making Ms. Byble lethargic. (D—Herschel—TR. 39-87. Doc. No. 300209.)

261.) Ms. Herschel informed the physician of her conclusion that the medication was making Betty Byble lethargic in January of 1974. (D—Herschel—TR. 39-88, lines 14-18.)

DR-260-261.) Layne Erban Herschel's testimony in this regard referred to late January, 1974. See Defendants Proposed Findings D-191-D-198.

262.) Ms. Bybel often made complaints about her medication. She would ask to have her medication changed. (D—Herschel—TR. 39-74, lines 8-10.)

DR-262.) Layne Erban Herschel also testified that as the result of these requests, her medication was changed, from Thorazine, to Haldol, to Navane. Tr. 39 at 74 (Herschel).

263.) Prior to seeing the needle and being forcefully medicated, she had not been acting out in any way. (P—Franceen—TR. 20-49, 50, lines 19-25, 1-6.)

264.) Elizabeth Bybel was over-sedated from medication in January or February of 1974 in that her speech was slurred, there was excessive saliva coming from her mouth, there was a vacant look in her eye which was totally contrasted with how she would normally look which was bright and alert. She had

a kind of lilting gait and she moved slowly. (P—Franceen—TR. 20-50, lines 8-17.)

271.) Elizabeth Bybel complained about side effects. She complained to Dr. Schildkrout about feeling too drugged, sleepy. She also complained that the medication was killing her; that she had all kinds of fantasies about what the medication was doing as well as other things that were not pharmacologically sound based on her fears. (D—*SCHILDKRAUT*—TR. 44-22, 23, lines 19-25, 1-5.)

272.) Mrs. Bybel felt abused about all kinds of things. (D—*SCHILDKRAUT*—TR. 44-23, lines 8-9.)

273.) There were times when Betty Bybel was terrified of needles. (D—*SCHILDKRAUT*—TR. 44-23, lines 10-11.)

DR-273.) Betty Bybel was at times terrified about almost anything that went on in life, including needles. At other times, she was not frightened of needles and participated in Lithium treatment, including the necessary weekly blood tests in which blood was withdrawn by needles. Tr. 44. at 23 (Schildkrout).

274.) If Elizabeth Bybel feared the hypodermic needle it would increase her anxiety about receiving it. (D—*KANTAR*—TR. 14-18, lines 3-10.)

275.) At times Elizabeth Bybel felt very abused and at other times she felt the medication was in her interest. (D—*KANTAR*—TR. 14-40, 41, lines 23-25, 1-2.)

276.) Certain psychotic drugs had some stiffening for Elizabeth Bybel and had a sedative effect which she considered a side effect. (D—*KANTAR*—TR. 14-38, lines 23-25.)

DR-276.) Dr. Kantar was not aware of the side effect of medications on Betty Bybel prior to January, 1975. Tr. 14 at 38 (Kantar).

277.) Elizabeth Bybel refused her medication on a number of occasions, while Dr. *SCHILDKRAUT* was a resident. (D—*SCHILDKRAUT*—TR. 44-22, lines 15-18.)

278.) "Everyone in the place" was forced to take medication. (P—*BYBEL*—TR. 39-15, line 8.)

279.) In one incident Elizabeth Bybel was stripped naked in the corridor, grabbed by six attendants, men, and was given a needle in her rectum. (P—*BYBEL*—TR. 39-15, lines 15-17.)

280.) She described having physical effects from the needle itself, which caused the muscles to tighten up and would leave a lump on her rectum. (P—*BYBEL*—TR. 39-15, lines 20-25; 39-16, lines 1-3.)

281.) It was painful when she received the needle. (D—BYBEL—TR. 39-16, lines 4-5.)

282.) She both requested and refused Lithium. (P—*BYBEL* —TR. 39-16, lines 8-12.)

283.) She refused Lithium because there were many times that she felt people thought she was a heroin addict because they were taking bloods all the time. (P—*BYBEL*—TR. 39-16, lines 21-25; 39-17, lines 1-4.)

283.) Betty Bybel never told Layne Erban that the reason she refused Lithium was because she was afraid someone might perceive her as being a heroin addict. Tr. 40 at 10 (Herschel). See also Defendants' Proposed Finding D-277.

284.) She never sat down with the doctor so he could review with her the effects and side effects of the medication she was taking. (P—*BYBEL*—TR. 39-17, lines 5-8.)

285.) No one ever talked to her about Lithium before she received it. (P—*BYBEL*—TR. 39-17, lines 19-21.)

286.) In 1974 she tried to organize patients concerning refusing medications. There was a J.L. and she can't remember the other patients for whom she did this. (P—*BYBEL*—TR. 39-17, 18, lines 22-25, 1-3.)

287.) In 1974 on A6 Mrs. Bybel accused the staff of making J.E. beg for cigarettes like an animal. (P—*BYBEL*—TR. 39-18, lines 8-11.)

288.) She told the other patients that if they didn't want the medication they could refuse it. At one point she was put into

seclusion for a period of about three or four days for this. (P—*BYBEL*—TR. 39-18, lines 11-18.)

289.) Mrs. Bybel received enough Thorazine to put a person asleep for eight to fourteen hours. (P—BYBEL—TR. 39-12, lines 18-21.)

DR-289.) In fact, Betty Bybel testified that one Thorazine, 250 milligrams, would put a person to sleep for eight to fourteen hours. Tr. 39 at 12 (Bybel). Dr. Kantar, however, testified that 2000 mg. of Thorazine did not act as a chemical restraint for Betty Bybel. Tr. 11 at 122-123 (Kantar).

290.) She did not want the Thorazine they were giving her. She told the staff it made her like a zombie. It caused thickening of her tongue; it made her very slow; "like a halfwit, like a zombie." (P—*BYBEL*—TR. 39-14.)

291.) It slowed down her thinking. (P—*BYBEL*—TR. 39-14, 15, lines 24-25, 1.)

292.) She took the Thorazine because she was forced to take it. (P—*BYBEL*—TR. 39-15, lines 5-6.)

293.) The sedating effect of the medication Elizabeth Bybel was receiving would have the effect of reducing her assertiveness. (P—*KANTAR*—TR. 14-39, lines 22-25.)

DR-293.) One reason Thorazine was used for Betty Bybel was to quiet her down sufficiently to enable her to have some discretion about what she was doing. It was not used to "snow" or to "stifle" Betty Bybel. Tr. 48 at 30-32 (Kantar).

A manic patient, such as Betty Bybel, has behavior that is very active, very belligerent, very much out-of-control; he or she acts as if there is a compulsion to behave in this very agitated, belligerent uncontrolled fashion. The goal in treating this patient is to help him or her quiet down enough so there is inner decision-making and choice as to what behaviors the patient wants to engage in, rather then being under this compulsion. Tr. 48 at 30, 31 (Kantar).

What, in fact, was "stifling" Betty Bybel was the pressure and compulsion to be as active as she was. Tr. 48 at 32 (Kantar).

When Dr. Kantar testified that Betty Bybel was given medication to reduce her anxiety, he was referring to anxiety marked by extreme agitation and terror. Tr. 48 at 16, 17 (Kantar).

294.) There is a very thin line between the medication being effective and when it crossed that line it over sedates the patient. (D—Herschel—TR. 39-87, 88, lines 24-25, 1-2.)

DR-294.) Layne Erban Herschel's testimony here referred to Betty Bybel's treatment in late January, 1974. See Defendants' Proposed Findings D-191-D-198, D-182, D-183.

295.) Slurred speech, slow thinking, and a zonked out character, all are side effects of the medication that Elizabeth Bybel was receiving in the early part of 1974. (D—Myerson—TR. 62-63, lines 3-23.)

DR-295.) Dr. Myerson's testimony was that the side-effects of slurred speech and slow activity went hand-in-hand with the necessity of treating Betty Bybel with high dosages of phenothiazines in late January and early February, 1974. Tr. 62 at 63, 64 (Myerson). See Defendants' Proposed Findings D-191-D-198, D-182, D-183.

DR-297-298.) Plaintiffs have not established that when Betty Bybel refused medication between January, 1973, and April, 1975, and was involuntarily medicated, there was no emergency at the time. See Defendants' Proposed Findings D-219-D-222; D-215-D-216; D-222-D-226.

298.) The A tin Unit overreacted to Mrs. Bybel's provocative behavior as indicated by the nurses' notes which describe her as depressed and sleeping, lethargic rather than aggressive. The use of seclusion was also an overreaction and it was unacceptable medical practice in the period of January, 1973 to April, 1975 to have forcibly medicated Elizabeth Bybel by using a hypodermic needle in circumstances where she was refusing that medication and where there was no genuine emergency being presented to the staff. (P—Messinger—TR. 32-37, lines 1-8.)

299.) It is very likely that the medication and the doses that

Elizabeth Bybel was receiving would account for the slow thinking, slurred speech, and generally zonked out appearance that witnesses Cariello and . . .

300.) She told Dr. Eisenstadt and Dr. *SCHILDKRAUT*. P—*BYBEL*—TR. 39-22, limes 10-21.)

301.) In response to the question, "did they tell you that you had to take the medication," her answer was "Richard, it was forced upon me." (P—*BYBEL*—TR. 39-23, lines 20-21.)

302.) From January 1, 1973 to April 30, 1975, medication was prescribed for the treatment of Elizabeth Bybel in at least the total daily amounts for the periods in the following attachments: (Stipulations for Elizabeth *BYBEL*, pages A47-A71.)

303.) Mrs. Bybel's medication records indicate that her attempts to refuse anti-psychotic medication were only honored four times. (D—Herschel—TR. 40-58, 59.)

DR-303.) Layne Erban Herschel did not testify that Betty Bybel's attempts to refuse antipsychotic medication were only honored four times. Tr. 40 at 58, 59 (Herschel). While plaintiffs' counsel Cole made such a representation to the Court, in fact, Betty Bybel's records reflect that she refused her regular antipsychotic medication and these requests were honored, on at least these dates:

January 15, 1973	(12 noon & 4 PM)	Pl.Ex.9, Doc.No. 300034
April 19, 1973	(8 AM)	Pl.Ex.9, Doc.No. 300101
August 4, 1973	(8 AM)	Pl.Ex.9, Doc.No. 300146A
September 2, 1973	(H.S.)	Pl.Ex.9, Doc.No. 300147B
September 14, 1973	(4PM and 8 PM)	Pl.Ex.9, Doc.No. 300147B
December 17, 1973	(4 PM and 8 PM)	Pl.Ex.9, Doc.No. 300192
January 25, 1974	(H.S.)	Pl.Ex.9, Doc.No. 300698
January 28, 1974	(H.S.)	Pl.Ex.9, Doc.No. 300698
April 21, 1974	(8 AM)	Pl.Ex.9, Doc.No. 300703
November 7, 1974	(H.S.)	Pl.Ex.9, Doc.No. 300709
February 3, 1975	(H.S.)	Pl.Ex.9, Doc.No. 300714

In addition, Betty Bybel's antipsychotic medications were "held" by nursing personnel and she did not receive them on at least the following dates:

January 12, 1973	(12 noon)	Pl.Ex.9, Doc.No. 300034
January 14, 1973	(H.S.)	Pl.Ex.9, Doc.No. 300034
January 15, 1973	(H.S.)	Pl.Ex.9, Doc.No. 300034
January 18, 1973	(4 PM and H.S.)	Pl.Ex.9, Doc.No. 300034
April 18, 1973	(4 PM)	Pl.Ex.9, Doc.No. 300101
April 20, 1973	(8 AM)	Pl.Ex.9, Doc.No. 300101
April 23, 1973	(4PM)	Pl.Ex.9, Doc.No. 300101
August 3, 1973	(4 PM and 8 PM)	Pl.Ex.9, Doc.No. 300146A
September 3, 1973	(4PM)	Pl.Ex.9, Doc.No. 300147B
January 30, 1974	(4PM)	Pl.Ex.9, Doc.No. 300698
January 31, 1974	(4 PM)	Pl.Ex.9, Doc.No. 300698
March 17, 1974	(4 PM and H.S.)	Pl.Ex.9, Doc.No. 300701
March 20-25, 29-31, 1974	(H.S.)	Pl.Ex.9, Doc.No. 300701
November 11-12, 1974	(H.S.)	Pl.Ex.9, Doc.No. 300709
February 5, 1975	(H.S.)	Pl.Ex.9, Doc.No. 300714

304.) According to Dr. *SCHILDKROUT*, the drug of choice for Betty Bybel was Lithium. He had given it to her for several reasons. He felt it was an effective drug, and that it had been quite helpful. (D—*SCHILDKROUT*—TR. 43-65, lines 9-20.)

(III.) *EACH OF THE DEFENDANTS GILL, KANTER AND SCHILDKROUT WERE AWARE OF OR INTENTIONALLY OR RECKLESSLY AVOIDED THEIR RESPONSIBILITY TO BE INFORMED THAT SECLUSION AND MEDICATION WAS BEING USED UPON ELIZABETH BYBEL UNDER CIRCUMSTANCES WHERE IT WAS NOT PRIVILEGED AS AN EMERGENCY PURSUANT TO M.G.L. c. 123, §§1, 21.*

Each of These Defendants Was Knowingly and Intentionally Responsible for Substantial Periods of Seclusion for Elizabeth Bybel.

(A.) *Dr. Gill's Responsibility for the Seclusion and Medication of Elizabeth Bybel.*

317.) Doctors in the Austin Unit were notified if a patient was actually forcibly medicated. They would learn at rounds in the morning or if they were present on the ward at the time or they were often involved in the actual forcible medication. (D—*GILL*—TR. 64-58, lines 1-7.)

318.) Ms. Herschel was responsible for among other things the ward A6 as the nursing supervisor for the daytime. Her responsibility on that ward was to oversee the nursing care on the ward and the work of the mental health workers. (D—Herschel—TR. 39-36, lines 4-5, 11-21; D—*KANTAR*—TR. 11-12, lines 19-23.)

319.) Layne Erban during the period in question had the power to set policy for the attendants and nursing staff in the Austin Unit. (D—*KANTAR*—TR. 11-14, lines 1-5.)

DR-319.) Dr. Kantar testified that during the period that Layne Erban was building nursing supervisor, it was her responsibility to make sure that the policy which existed was followed. Tr. 11 at 14 (Kantar).

320.) Layne Erban had among her responsibilities communicating ideas or ways on which an administrative meeting would decide issues in regards to patients. She would discuss who was going to be where as far as the staff was concerned. (D—*KANTAR*—TR. 11-14, lines 20-24.)

2. Defendants' Proposed Findings of Fact and Plaintiffs' Rebuttal *

BETTY BYBEL—MALPRACTICE AND CIVIL RIGHTS CLAIMS

(I.) HER ILLNESS

(A.) *Her First Admission to the Austin Unit*

D-1. Betty Bybel was first admitted to the Austin Unit on January 3, 1973, by order of the Municipal Court of the South Boston District for observation, following her arrest for drunkenness and her subsequent disruption of a court hearing. P. Ex. 7, Doc. Nos. 300026, 300025, 300027, 300022, 300023.

D-2. At the time of her first admission to the Austin Unit, Betty Bybel had a history of two prior hospitalizations for the treatment of mental illness. Pl. Ex. 7, Doc. Nos. 300027, 300001.

D-3. At the time of her commitment to the Austin Unit in January, 1973, Betty Bybel was yelling, fighting, unwilling to discuss her case with anyone, disrobing, breaking windows, and cutting herself. Pl. Ex. 7, Doc. No. 300025

(B) *Diagnosis*

D-4. During the period from January, 1973, through April 25, 1975, Betty Bybel's psychiatric diagnosis was manic-depressive psychosis, (Tr. 39 at 80 [Herschel]), although she was also diagnosed as having schizophrenia, schizo-affective type. Tr. 43 at 62, 63 (Schildkrout); Pl. Ex. 7, Doc. No. 300048.

(C.) *Her Behavior - General*

D-5. The majority of the time that Betty Bybel was in the Austin Unit, she was in a severe manic state. Tr. 39 at 97 (Herschel).

PR-1). Elizabeth Bybel between January of 1973 and the end of April of 1975, spent a great deal of time out of the hospital. She was discharged from the hospital on a number of occasions, and in one occasion, as a result of a

* Plaintiffs' Rebuttals are designated "PR"

commitment hearing, the hospital commitment petition was denied and she was allowed to go home. (D-5) (See Plaintiffs' Proposed Findings of Fact, #8, pages 701-706.)

PR-2.) There are a number of factors which indicate that Elizabeth Bybel was not in a constant state of emergency between January of 1973 and the end of April of 1975, as suggested by Layne Herschel and Dr. Meyerson. She was discharged voluntarily by the hospital on many occasions, throughout this period. (See Plaintiffs' Proposed Findings of Fact #8, pages 701-706.)

PR-3.) She was given diagnoses which were inconsistent with a description of constantly out-of-control behavior. (See Proposed Findings of Fact #9, page 706. (D-Meyerson TR. 63-66; 63-67.) D-5; D-6; D-7; D-8; D-9; D-10.)

D-6. Betty Bybel's behavior changed from agitated and manic to periods of severe depression. Tr. 43 at 59, 62 (Schildkrout).

D-7. Betty Bybel experienced extraordinary hyperaggressiveness and assaultiveness intermingled with periods of depression, with no real relief or remissions from the illness. Tr. 63-at 14 (Myerson).

D-8. The changes in Betty Bybel's behavior sometimes occured suddenly. Tr. 43 at 61, 62 (Schildkrout).

D-9. At times, Betty Bybel suffered from extreme depression, when her speech was retarded and she had difficulty talking and broke into tears spontaneously. On those occasions, she would spend days lying in bed, not doing anything. Tr. 39 at 99, 100 (Herschel).

D-10. At times, Betty Bybel experienced periods of depression lasting weeks at a time, during which she sat in one place and said very little and occasionally talked about wanting to be dead. Tr. 43 at 62. (Schildkrout).

D-11. At times during the late winter and spring of 1975, Betty Bybel said that she was going to kill herself and there

was nothing the Austin Unit staff could do about it. Tr. 43 at 61 (Schildkrout).

PR-4.) During the Spring of 1975 during a period of prolonged seclusion the Austin Unit knew that Elizabeth Bybel was a suicidal threat because she had informed both Dr. Schildkrout and Layne Herschel that she was going to kill herself. (D-11). (D-Schildkrout TR. 43-61.)

PR-5.) Nevertheless, they allowed her to be placed in locked seclusion by herself rather than having someone with her even in seclusion, or leaving the seclusion room door open so that she would not totally cut off from others on the outside. (P-Messinger TR. 32-21. D-Meyerson TR. 62-43.)

D-12. Even when Betty Bybel was depressed, she was able to spontaneously get up and start running around the ward, getting into fights, then immediately return to the depression that she was experiencing. TR. 43 at 62 (Schildkrout).

D-13. Betty Bybel had delusions that she was a member of a top secret organization in the United States Government; that the FBI was coming to get her; and that she was going to marry the President. Tr. 43 at 59 (Schildkrout).

D-14. Betty Bybel often had delusions that she was pregnant and that she was married, or about to be married, to various staff members. Tr. 43 at 61 (Schildkrout).

D-15. When Betty Bybel experienced delusions, she was terrified of her condition. Tr. 43 at 59 (Schildkrout).

D-16. On many occasions, Betty Bybel told Layne Erban that she had married someone, when in fact she had not. Tr. 40 at 12. (Herschel).

D-17. Betty Bybel often had a delusion that she was pregnant or having a miscarriage, which, upon physical examination and with the exception of her pregnancy in 1976, was not true. Tr. 40 at 12 (Herschel).

D-18. At times Betty Bybel denied that she was mentally ill. Def. Ex. Z6, p. 66 (Bybel); Def. Ex. Z5, p. 47 (Bybel); Tr. 39 at 97-99 (Herschel).

(D). *Her Manic Behavior - General*

D-19. When Betty Bybel was in a manic state at the Austin Unit, she was in constant movement, not stopping or sitting still; she was up, pacing, screaming, yelling, unable to carry on a conversation for any length of time. She maintained constant moving activity, eating very poorly and not sleeping. Tr. 39 at 97-99. (Herschel).

PR-6). Betty Bybel's manic behavior on the Austin Unit is described in this section. The court may want to compare her description in a manic state with that of Willie Wadsworth, who was alleged to be in a hyper manic state while in seclusion in December and January of 1975. She is described as being in constant movement, not stopping or sitting still; pacing, screaming, yelling, unable to carry on a conversation for any length of time. "She maintained constant moving activity, eating very poorly and not sleeping." (D-19). (D-Herschel TR. 39-97; 39-98; 39-99).

D-20. When Betty Bybel was in a manic state at the Austin Unit, she was hostile and, upon any frustration, screamed and fought out, beaking into rages precipitously. Tr. 39 at 97-99 (Herschel).

D-21. When Betty Bybel was in a manic state at the Austin Unit, she continuously filled her room with the belongings of others. Tr. 39 at 97-99 (Herschel).

D-22. When Betty Bybel was in a manic state at the Austin unit, she constantly complained about her body and was concerned that people were doing injury to her body. Tr. 39 at 97-99. (Herschel).

D-23. When Betty Bybel was in a manic state at the Austin Unit, she denied she was a patient or that there was anything wrong with her. Tr. 39 at 97-99 (Herschel).

D-24. When Betty Bybel was in a manic state at the Austin Unit, she was sadistic to other patients, often attacking them verbally about their personal lives. She exhibited a

vicious and primitive violence to patients and staff. Her attacks included tearing hair out of peoples' heads and trying to burn others with cigarettes. Tr. 39 at 97-99 (Herschel).

D-25. When Betty Bybel was in a manic state at the Austin Unit, her mental status included a constant flight of ideas and inability to concentrate on any one subject. Tr. 39 at 97-99 (Herschel).

D-26. When Betty Bybel was in a manic state, the constant stimulation of the ward often increased her mania, her hyper-activity, her lack of sleep, and her constant movement. Tr. 39 at 100, 101 (Herschel).

D-27. During ward meetings at the Austin Unit in January, 1975, Betty Bybel ran into the meetings, yelled and screamed that one of the patients had done something terrible to her, and cursed at people. She yelled at the staff that they were terrible and were trying to kill the patients. She created a massive frenzy in the whole ward which was very frightening for her, the patients, and the staff. Tr. 43 at 60 (Schildkrout).

D-28. When Betty Bybel was out of control, she was very excited; her movements would be very rapid; she spoke very loudly and in a very high-pitched voice; she screamed and was assaultive. Tr. 71 at 42 (Crumbley).

D-29. At times when Betty Bybel's behavior was out of control, she removed her clothes. Prior to her admission in January, 1973, she had removed her clothing and arrived at the Austin Unit dressed only in a bra, underpants, boots, and a coat. Pl. Ex 7. Doc. Nos. 300025, 300028. Prior to her admission in April, 1973, she had been running around the streets naked. Pl Ex. 7, Doc. Nos. 300045, 300047. Prior to her admission in May, 1973, her agitated behaviour included undressing. Pl Ex. 7, Doc. No. 300052. On at least one occasion when she was on the ward out of control, she had removed some of her clothing. Tr. 71 at 50 (Crumbley).

E. *Her Assaultive and Violent Behavior*

D-30. On occasions, Betty Bybel hit other patients. Tr. 39 at 94. (Herschel). On occasions, Betty Bybel hit staff members. Tr. 39 at 95, 96 (Herschel); Tr. 22 at 16 (Cariello).

D-31. At times, Betty Bybel physically attacked staff members and other patients and was secluded. Pl. Ex. 7, Doc. Nos. 300044, 300165, 300174, 300187, 300196, 300372, 300386.

D-32. At times Betty Bybel's behavior escalated from verbal attacks to physical attacks in which she punched people. Tr. 43 at 60. (Schildkrout).

D-33. Betty Bybel attempted to strangle Donna Hunt. Def. Ex. R, p. 77 (Hunt).

D-34. At times when Dr. Schildkrout attempted to give Betty Bybel a physical examination, she punched him. Tr. 43 at 61 (Schildkrout).

D-35. On one occasion when Betty Bybel was in seclusion and Dr. Schildkrout was taking her blood pressure, she grabbed the tube on his sphygmomanometer, pulled it across the seclusion room, and broke the blood pressure cup in half. Tr. 43 at 61 (Schildkrout).

D-36. On February 5, 1975, Betty Bybel attacked Austin Unit staff members Judy Crane and Lydia Cassorla. Mrs. Bybel jumped Judy Crane from behind, pulling out a large clump of her hair. She next grabbed Lydia Cassorla by the hair, pulled her to the ground, pulled out a large clump of her hair, and bit her in the face. As the result of this attack, Miss Cassorla required hospital treatment and teeth marks remained in her face. Tr. 41 at 23, 24 (Crane).

D-37. Betty Bybel bit attendant Lydia Dawes on the face, drawing blood. Betty Bybel felt she had done nothing wrong and did not understand the implications of what she had done. Tr. 43 at 62. (Schildkrout).

D-38. In the spring of 1975, Betty Bybel attempted to burn an Austin Unit attendant on the face with a cigarette. Pl. Ex. 7, Doc. No. 300267.

D-39. At times Betty Bybel's verbal attacks escalated to physical attacks in which she punched people. Tr. 43 at 60 (Schildkrout).

F. *Her Provocative Behavior*

D-40. Betty Bybel's behavior was provocative to other patients. Tr. 20 at 44 (Franseen).

D-41. At times Betty Bybel provoked other patients to the point that they threatened her with physical injury. Tr. 71 at 53. (Crumbley).

D-42. At times Betty Bybel's behavior provoked other patients to physically attack her. Pl. Ex. 7, Doc Nos. 300044, 300250.

D-43. On at least one occasion when Betty Bybel created a disturbance, one of the patients became angry at her for creating a disturbance and she struck that person. Tr. 71 at 49, 50 (Crumbley).

D-44. As Betty Bybel herself admitted, her yelling on the ward upset other patients who then also began yelling, until the whole ward became upset and were yelling. Def. Ex. Z6, p. 16 (Bybel).

D-45. Betty Bybel inevitably riled up other patients. She and James Colleran, for example, at times started riling each other up; this behavior ultimately resulted in terrible fights. Tr. 43 at 60 (Schildkrout).

D-46. From the time when Betty Bybel first arrived on the ward, she stole money and personal belongings of other patients. Tr. 39 at 83 (Herschel); Def. Ex. R, pp. 75-76 (Hunt).

D-47. Betty Bybel's stealing incited anger and threats of violence by other patients toward her. Tr. 39 at 83 (Herschel).

D-48. When Betty Bybel stole from Donna Hunt, Donna felt like beating her up. def. Ex. R, pp. 76-76 (Hunt).

D-49. In a mental hospital ward, someone who steals from others is a terrible menace, aggravating other patients. Betty Bybel very frequently stole things on the ward and was often into everyone's property. Tr. 65 at 69. (Gill).

D-50. Betty Bybel was very intrusive and very bothersome to other patients and staff. Tr. 65 at 69, 70. (Gill).

D-51. Most of the patients at the Austin Unit disliked Betty Bybel. Tr. 40 at 3. (Herschel); Tr. 65 at 76, 77 (Gill).

D-52. Most patients at the Austin Unit were frightened of Betty Bybel. Tr. 40 at 3 (Herschel).

D-53. Betty Bybel frightened other patients by telling them that they were being mistreated and that things were terrible. Tr. 43 at 60, 61 (Schildkrout).

D-54. Betty Bybel's admission to the ward caused tremendous chaos among other patients. Tr. 40 at 3 (Herschel).

D-55. Other Austin Unit patients responded to Betty Bybel's admission to the hospital with a sense of dread. Tr. 65 at 69 (Gill).

D-56. Very often patients requested to leave the hospital when Betty Bybel was admitted to the Austin Unit. Tr. 65 at 70 (Gill).

D-57. Frequently patients stated to Dr. Gill about Betty Bybel: "You have to shut her up, Doctor; have to get her out of here or get me out of here." Tr. 65 at 70 (Gill).

D-58. When Betty Bybel escaped from the Hospital, patients were relieved that she was gone because she was so loud and intrusive. Tr. 65 at 69 (Gill).

* * *

(C.) *Medication As Part of Betty Bybel's Treatment at the Austin Unit*

(1). *General*

D-180. Lithium was the drug of choice for Betty Bybel. Tr. 43 at 65 (Schildkrout).

D-181. During periods when Betty Bybel was extremely psychotic, she needed medication in addition to Lithium to help her contain her thoughts, become more organized and reduce the amount of psychosis she was experiencing. Tr. 43 at 65 (Schildkrout).

D-182. The usual medication practice in treating a patient

who is suffering from manic-depressive illness and who is admitted to a hospital in an acute manic state is to prescribe one of the phenothiazines, or Haldol, to quiet the person down and make them accessible to another chemical therapy, namely, the use of Lithium, which is taken by mouth. Tr. 62 at 60, 61. (Meyerson).

D-183. The use of antipsychotic drugs in mania and depression has met with some success. Haloperidol (Haldol) and chlorpromazine (Thorazine) are both effective in the treatment of mania and are often used concommitently with the institution of Lithium therapy. Often high dosage must be used to control mania. Goodman & Gilman, The Pharmacological Basis of Therapeutics, 5th Ed., at p. 173; Tr. 60 at 146 (Kahn).

D-184. The purpose of prescribing Thorazine for Betty Bybel was to bring her down and help her manic psychosis. Many times it did not have that effect. Tr. 40 at 69. (Herschel).

D-185. The purpose of prescribing Thorazine for Betty Bybel was *not* to sedate her and reduce her assertiveness. Tr. 40 at 68 (Herschel).

D-186. Betty Bybel was not medicated in order to prevent her from being assertive. Betty Bybel essentially could not be assertive, which was the major reason that she acted in such a highly charged, flamboyant, aggressive, belligerent and sometimes assaultive manner. The major problem caused by her illness was her great difficulty in asserting herself.

D-187. For the most part, antipsychotic medication did not sedate Betty Bybel. Tr. 40 at 63. (Herschel).

D-188. Thorazine at a recommended dosage never sedated Betty Bybel. Tr. 40 at 64 (Herschel).

D-189. Betty Bybel was not over-sedated from her antipsychotic medication. Tr. 14 at 38, 39 (Herschel).

PR-29. Although the defendants alleged that Betty Bybel was never over-sedated from her antipsychotic

medication, at the same they assert that Layne Erban informed her physician that Mrs. Bybel was unable to attend groups on the ward because of her medication. The medication was reduced and her lethargy allegedly decreased thereafter. (D-189; D-192.) (D-Herschel Tr. 39-87; 39-88; 39-89.)

D-190. The Austin Unit records for Betty Bybel were very good and adequate for a trained physician to review her sequence of medicaton. Tr. 63 at 82, 84 (Meyerson).

(2.) *Her Medications During the Winter of 1974*

D-191. During late January, 1974, Betty Bybel was receiving Lithium and Thorazine; as these two drugs are combined, they begin to bring the patient down from a manic phase. As this happens, the patient needs less medication and the physician must decrease the dosage. Tr. 40 at 64. (Herschel).

D-192. At a time in late January, 1974, when Layne Erban wrote in Betty Bybel's record that she was unable to attend groups on the ward because of her medication, (Pl. Ex. 7, Doc. No. 300209), Betty Bybel had been receiving a large dose of Thorazine in response to her manic and out-of-control state. After noting that her medication needed to be cut back, Layne Erban informed Mrs. Bybel's physician of this fact, the medication order was reduced, and Mrs. Bybel's lethargy decreased thereafter. Tr. 39 at 87-89 (Herschel).

D-193. It was acceptable medical practice for the psychiatrists and psychiatric residents at the Austin Unit to have prescribed and authorized Thorazine and Lithium in the dosages which were prescribed for Betty Bybel during January and February, 1974. Tr. 62 at 61 (Myerson).

D-194. The physicians and nurses at the Austin Unit were closely monitoring Betty Bybel in order to note the effects of the medication she was receiving in late January and early February, 1974. Tr. 62 at 61, 62 (Meyerson).

D-195. Every indication from Betty Bybel's Austin Unit

records is that her medication orders were reviewed daily during late January and early February, 1974. Tr. 63 at 13, 14 (Meyerson).

PR-30.) According to Dr. Meyerson, Elizabeth Bybel's medication was being reviewed by her doctors daily during late January and early February of 1974. (D-195.)

PR-31.) This is the period when certain attendants on the Austin Unit observed Mrs. Bybel being snowed by the medication and immediately following the period when Layne Erban was quoted as having said that Elizabeth Bybel would have to be snowed in order to stop her challenge of the authority of the staff on the Austin Unit. Plaintiffs' Findings of Fact for Elizabeth Bybel, #206, pages 788-789.)

D-196. The practices of the Austin Unit physicians and nurses in monitoring Betty Bybel's medication during late January and early February, 1974, constituted acceptable medical practice. Tr. 62 at 62, 63 (Meyerson).

D-197. The side-effects of slurred speech and slowed activity went hand-in-hand with the necessity of treating Betty Bybel with high dosages of phenothiazines in late January and early February, 1974. Tr. 62, 63, 64 (Meyerson).

PR-32.) According to Dr. Meyerson, the side effects of slurred speech and slowed activity went hand in hand with high dosages of phenothiazines prescribed for Betty Bybel in late January and early February of 1974. (D-197.) (D-Meyerson Tr. 62-63; 62-64.)

D-198. The amount of medication which Betty Bybel was receiving during late January and early February, 1974, was consistent with acceptable medical practice, even if it did cause certain side effects, such as slurring of speech. Tr. 62 at 63. (Myerson).

PR-33. According to Dr. Meyerson, the amount of medication which would have lead to this slurred speech

and slowed activity in January and February of 1974 was consistent with acceptable medical practice in his opinion. (D-198.) (D-Meyerson Tr. 62-63)

* * *

(D.) *Informed Consent*

(2.) *Betty Bybel Was Informed of the Risks and Benefits of Medication*

D-204. Betty Bybel had the opportunity to discuss her medication at weekly privilege meetings with patients and staff present. At these meetings she often made complaints about medication and requested to have her medication changed. As a result of these requests, her medication was often changed from Thorazine to Haldol to Navane. Tr. 39 at 74. (Herschel).

PR-35.) The defendants admit that Betty Bybel often complained about her medication and requested to have the medication changed. The court may consult Mrs. Bybel's medication records to indicate how frequently those changes were made. (D-204.) (Plaintiffs' Proposed Findings of Fact, pages 797-822.)

D-205. Dr. Schildkrout had frequent conversations with Betty Bybel about the course of her treatment and, in particular, about her medication. Tr. 44 at 62. (Schildkrout).

D-206. Throughout the six months that Dr. Schildkrout was at the Austin Unit, from January through June, 1975, he had frequent discussions with Betty Bybel regarding the side-effects and beneficial effects of her medication. Tr. 43 at 66, 67. (Schildkrout).

D-207. Betty Bybel complained that antipsychotic medication was killing her. She had all kinds of fantasies about what the medication was doing to her which were not pharmacologically correct, but based upon her own fears. Tr. 44 at 23, 24 (Schildkrout).

PR-36.) Dr. Schildkrout admits that Elizabeth Bybel had "all kinds of fantasies about what the medication was doing to her." (D-207.) (D-Schildkrout Tr. 44-22, 44-23.)

D-208. In response to complaints Betty Bybel made to Dr. Schildkrout about the medications she was receiving, Dr. Schildkrout changed her prescription to Navane in the hopes that it would not cause her as much distress, (Tr. 44 at 62, 63 [Schildkrout]), as well as to ensure that she received medication that was effective in helping her with her psychosis. Tr. 43 at 66 (Schildkrout).

D-209. Layne Erban informed Betty Bybel of the risks and benefits of Thorazine on many occasions, including which side effects were serious and which would eventually disappear or were treatable with other medications, such as Artane or Cogentin. Tr. 40 at 8, 9 (Herschel).

D-210. Layne Erban explained to Betty Bybel over and over again the risks and benefits of Lithium. Tr. 40 at 9, 10 (Herschel).

D-211. Layne Erban posted a list of the side effects of Lithium in the nurses' station so that attendants could be observant of possible side effects developing in Betty Bybel. Tr. 40 at 9, 10 (Herschel).

D-212. As Betty Bybel herself admitted, her therapist sat down and explained Lithium to her. Def. Ex. Z6, p. 48 (Bybel).

D-213. At times, Betty Bybel agreed to take Thorazine; at times she asked for PRN Thorazine; and at times she refused to take Thorazine. Tr. 40 at 10. (Herschel).

PR-37.) The defendants admit that at times Elizabeth Bybel refused both Lithium and Thorazine. (D-213; D-214; D-217.)

D-214. At times, Betty Bybel has refused antipsychotic medication. Tr. 39 at 103 (Herschel).

D-215. On many occasions, Betty Bybel refused her antipsychotic medication and was not given it. Tr. 39 at 106 (Herschel).

D-216. At times, when Betty Bybel refused her antipsychotic medication and was not given it, her doctors' orders

included a standing i.m. order for medication if she refused. Tr. 40 at 112 (Herschel).

D-217. At times, Betty Bybel agreed to take Thorazine, but refused to take Lithium. Tr. 40 at 10, 11 (Herschel).

D-218. Plaintiffs have introduced no testimony that given Betty Bybel's condition and the beneficial effects of antipsychotic medications, a reasonable person would have refused antipsychotic medications under her circumstances.

3. *Involuntary and Forcible Medication*

D-219. As Betty Bybel admitted, the only times that she was given antipsychotic medication intramuscularly were three times when she was being admitted to the hospital and when she was being put in seclusion. Def. Ex. Z5, pp.15-16 (Bybel).

D-220. Betty Bybel was in a state of continuous psychiatric emergency lasting periods of months when she was a patient at the Austin Unit between January, 1973, and the end of April, 1975. Tr. 40 at 112, 113 (Herschel); Tr. 62 at 35, 36; Tr. 63 at 11, 12 (Myerson).

PR-38.) The defendants contend that "the plaintiffs have introduced no testimony that given Betty Bybel's condition and the beneficial effects of antipsychotic medication, a reasonable person would refuse antipsychotic medications under her circumstances." The plaintiffs contend that such evidence is totally irrelevant to this case.

PR-39.) The defendants attempt to justify their involuntary medication of Elizabeth Bybel by asserting that, "Betty Bybel was in a state of continuous psychiatric emergency lasting periods of months, when she was a patient of the Austin Unit between January of 1973 to the end of April of 1975." (D-220.)

PR-40.) At the same time Elizabeth Bybel was discharged from the Austin Unit on a number of occasions. (See Plantiffs' Proposed Findings of Fact, pages 701-706.)

D-221. During those periods when she was hospitalized between January, 1973, through April, 1975, Betty Bybel presented a psychiatric emergency to the chief and staff of the Austin Unit, and she needed antipsychotic medication to control this emergency. Tr. 62 at 65, 66 (Myerson).

PR-41.) Dr. Meyerson again contends that during the time that Elizabeth Bybel was in the hospital in January of 1973 to April of 1975, in his opinion she was in a psychiatric emergency, as perceived by the staff and chief of the Austin Unit, and therefore that justified giving her antipsychotic medication to control that emergency. (D-221).

D-222. While a patient at the Austin Unit, Betty Bybel constituted a constant danger, not just a danger on a momentary basis. The danger was the very nature of her illness, and that did not wax and wane over the moments. Tr. 62 at 67 (Myerson).

PR-42.) According to Dr. Meyerson, while Elizabeth Bybel was a patient in the Austin Unit throughout this period, she was "a constant danger" and that her condition did not wax or wane over the moments. (D-222.)

D-223. The involuntary medication of Betty Bybel with antipsychotic medications during the periods of her hospitalizations from January, 1973, through April, 1975, constituted acceptable medical practice. Tr. 62 at 65 (Myerson).

PR-43.) Dr. Meyerson based his conclusion that the involuntary medication of Betty Bybel with antipsychotic medication during the periods of her hospitalization in January of 1973 to April of 1975 was accepted medical practice based on his assumptions that she was in a constant psychiatric emergency throughout this period. However, the many discharges and changes of diagnosis throughout this period support the conclusion that she was not in a constant state of emergency throughout this period. (D-223.)

PR-44.) According to Dr. Meyerson, "from January of 1973 through April of 1975, it was the standard procedure with a seriously disturbed patient such as Betty Bybel that nurses would first try to persuade the patient to take medication, and then if the patient refused, to give it without her consent." Of course, what constituted acceptable medical practice, according to Dr. Meyerson, changed in his opinion as a result of the temporary restraining order granted by this law suit in April of 1975. (D-Meyerson TR. 62-69; 62-70; 62-71; 62-72.)

D-224. From January, 1973, through April, 1975, it was the standard procedure with a seriously disturbed patient such as Betty Bybel that nurses would first try to persuade the patient to take medication, and then if the patient refused, to give it without her consent. Tr. 62 at 65 (Myerson).

PR-45.) Dr. Meyerson based his conclusion that it was acceptable psychiatric practice between January 1, 1973 and April 25, 1975 for the psychiatric residents and supervising psychiatrists to have involuntarily medicated Betty Bybel, in circumstances which were not limited to those in which she was imminently assaultive, on the basis that it was commonly done. However, he admitted that the situation changed as a result of this law suit, and its temporary restraining order. (D-224; D-225.) (D-Meyerson TR. 62—69-72.)

D-225. It constituted acceptable psychiatric practice from January 1, 1973, to April 25, 1975, for the psychiatric residents and supervising psychiatrists of the Austin Unit to have involuntarily medicated Betty Bybel in circumstances which were not limited to those in which she was imminently assaultive. Tr. 62 at 66, 67 (Myerson).

D-226. The medication of Betty Bybel by the Austin Unit in 1973, 1974, through April, 1975, constituted acceptable medical practice. Tr. 62 at 69 (Myerson).

(E.) *Good Faith*

(1.) *General*

D-227. The Austin Unit staff attempted to provide Betty Bybel with the most helpful and appropriate treatment. This included supplying her as much as possible with a consistent environment in which she could be cared for and attempting intensive psychotherapy with Layne Erban. Tr. 43 at 63 (Schildkrout).

D-228. When Betty Bybel ran away from the ward and escaped, Austin Unit staff members chased after her and were very concerned that she would kill herself. Tr. 43 at 61 (Schildkrout).

D-229. During the last winter and spring, 1975, Betty Bybel's behavior was at times so disruptive to the ward that it required and she received special attention from the staff. Tr. 43 at 72 (Schildkrout).

D-230. During the late winter and spring, 1975, there was an enormous amount of discussion among the staff about what to do to help Betty Bybel and a great deal of time spent by individual staff members talking to her. Tr. 43 at 72 (Schildkrout).

D-231. In the spring of 1975, when Betty Bybel was severely depressed and could not be left alone, staff members signed up to sit with her in the side day hall for whole days, notwithstanding the limited number of staff members available on the ward. Tr. 43 at 73 (Schildkrout).

PR-46.) The defendants admit that in the Spring of 1975 when Betty Bybel was severely depressed she could not be left alone. (D-231.) (D-*SCHILDKROUT* TR. 43-73.)

D-232. Betty Bybel received as much care as any other patient on the ward and more than most patients. Tr. 43 at 73, 74 (Schildkrout).

D-233. It is to the credit of the Austin Unit staff that they never called in the police in response to her violent or fire-setting behavior. Tr. 63 at 8 (Myerson).

D-234. It is to the credit of the Austin Unit staff that they never refused to treat Betty Bybel. Despite her behavior, the staff always responded by giving her the care they thought was appropriate at that moment in time. Tr. 63 at 8 (Myerson).

(2.) *Dr. Gill*

D-235. Dr. Gill conducted himself in the utmost good faith in fulfilling his responsibilities to Betty Bybel. Tr. 40 at 27, 28 (Herschel).

D-236. Dr. Gill was very concerned that Betty Bybel always receive good care while she was in the hospital. Tr. 40 at 29 (Herschel).

D-237. Dr. Gill often visited Betty Bybel and evaluated her condition when she was in the seclusion room. Tr. 40 at 28 (Herschel): Tr. 65 at 78 (Gill).

D-238. On many occasions Dr. Gill requested from staff members the reasons that Betty Bybel had been secluded. Tr. 65 at 78 (Gill).

D-239. Dr. Gill supervised Layne Erban on a one-to-one basis with her therapy with Betty Bybel. Tr. 40 at 28 (Herschel).

D-240. Dr. Gill directed Layne Erban to accompany Betty Bybel to the funeral of her brother because he concluded it would further help to develop a treatment alliance between Ms. Erban and Mrs. Bybel and because he concluded it was important to be in close contact with her and to help take care of her at a time when she was in such serious distress. Tr. 40 at 28 (Herschel).

D-241. Layne Erban continued to see Betty Bybel in therapy during late March and through April, 1975, at the suggestion of Dr. Gill, who concluded that it was very important for Betty that her treatment be continued in her crisis situation. Tr. 39 at 109 (Herschel).

D-242. Dr. Gill met with Betty Bybel and pleaded with her to settle down, to stop fighting with everyone, and to participate in her own treatment. Tr. 65 at 74, 75 (Gill).

D-243. Dr. Gill attempted to warn Betty Bybel that her fighting was doing her in. Tr. 65 at 74 (Gill).

D-244. At times Dr. Gill was able to convince Betty Bybel to participate in her own treatment, and she improved thereafter. Tr. 65 at 74, 75 (Gill).

D-245. Betty Bybel knew Dr. Gill's dedication and respected him. Tr. 40 at 25 (Herschel).

D-246. As Betty Bybel herself testified, she likes Dr. Gill and feels he is "a nice person." Tr. 39 at 10 (Bybel).

D-247. There is no evidence that Dr. Gill acted in bad faith in fulfilling his responsibilities to Betty Bybel.

(3.) *Dr. Kantar*

D-248. Dr. Kantar conducted himself to the utmost good faith in fulfilling his responsibilities to Betty Bybel. Tr. 40 at 32 (Herschel).

D-249. Dr. Kantar on several occasions visited Betty Bybel in seclusion. Tr. 40 at 32 (Herschel).

D-250. Dr. Kantar was very concerned that she not leave the Austin Unit and hurt herself or hurt other staff members. Tr. 40 at 32 (Herschel).

D-251. There is no evidence that Dr. Kantar acted in bad faith in fulfilling his responsibilities to Betty Bybel.

(4.) *Dr. Schildkrout*

D-252. Dr. Schildkrout conducted himself in the utmost good faith in fulfilling his responsibilities to Betty Bybel. Tr. 40 at 34 (Herschel).

D-253. Dr. Schildkrout worked very closely with staff members to ensure that Betty Bybel did not put herself in any situations where she would seriously hurt herself or other patients, or where she would escape and possibly kill herself. Tr. 40 at 34 (Herschel).

D-254. Dr. Schildkrout visited Betty Bybel in the seclusion

room in order to give her physical examinations and in order to ensure that she was receiving proper care, proper nutrition, and that she was not in any physical danger. Tr. 40 at 34 (Herschel); Tr. 43 at 61 (Schildkrout).

D-255. When Betty had physical complaints, Dr. Schildkrout attempted to give her physical examinations. Tr. 43 at 61 (Schildkrout).

D-256. Dr. Schildkrout honored Betty Bybel's refusal of Lithium. Tr. 43 at 67 (Schildkrout).

D-257. In response to Betty Bybel's preoccupation about her medication, Dr. Schildkrout frequently discussed with her the side-effects and beneficial effects of her medication. Tr. 43 at 66, 67 (Schildkrout).

D-258. When Betty Bybel complained of any number of problems, Dr. Schildkrout did his best to take care of them for her. Tr. 43 at 61 (Schildkrout).

D-259. During his six months at the Austin Unit, Dr. Schildkrout never gave up on Betty Bybel and at all times used his best efforts in attempting to bring about a favorable result. Tr. 46 at 64 (Schildkrout).

D-260. Betty Bybel likes Dr. Schildkrout. Tr. 39 at 22 (Bybel).

D-261. There is no evidence that Dr. Schildkrout acted in bad faith in fulfilling his responsibilities to Betty Bybel.

PR-47.) Dr. *GILL*, Dr. *KANTAR* and Dr. *SCHILDKROUT* all conducted themselves in bad faith as defined by 42 U.S.C. Sec. 1983, in a number of respects with regards to the medication of Elizabeth Bybel during the time that they were responsible for her care from January of 1973 until the end of April of 1975. Medicating her against her will in non-emergency situations, even if they considered that to be in her best interests at the time, constitutes bad faith as defined by that section, and renders them liable to her damages. (See Plaintiffs' Brief on Medication Issues, page 207, citing *Downs* v. *Sawtelle*, 574 F. 2d 1, 11 (1st Cir. 1978.).)

(III.) *Causation*

* * *

(C.) *Betty Bybel's Lack of Improvement in Late April, 1975, Was Caused by Her Repeated Escapes From the Hospital and Her Resistance to Treatment*

D-269. The lack of improvement in Betty Bybel's condition of the long term from January, 1973, to April 25, 1975, was substantially caused by her repeated escapes from the Austin Unit. Tr. 65 at 73 (Gill); Tr. 62 at 70 (Myerson); Pl. Ex. 7, Doc. No. 300263; Proposed Finding D-59.

D-270. The lack of improvement in Betty Bybel's condition over the long term from January, 1973, to April 25, 1975, was substantially caused by her refusal to participate in treatment. Tr. 65 at 74 (Gill).

D-271. While it is characteristic of Betty Bybel's illness that the patient will resist treatment, her resistence to treatment prevented her from having the opportunity for recovery. Tr. 62 at 70 (Myerson).

D-272. When Betty Bybel did participate in treatment, she improved considerably. Tr. 65 at 74, 75 (Gill).

D-273. As even plaintiffs' expert witness testified, Betty Bybel had difficulty "sticking with therapy." Tr. 35 at 52 (Messinger).

D-274. Betty Bybel also resisted medical treatment; she refused to allow Dr. Schildkrout to give her a physical examination, on one occasion punching him and, on another occasion, breaking his sphygmomanometer. Tr. 43 at 61 (Schildkrout).

(D.) *Betty Bybel's Lack of Improvement in Late April, 1975, was Caused by Her Refusal to Take Lithium*

D-275. The majority of the time that Betty Bybel was a patient in the Austin Unit, she refused to take Lithium. Tr. 40 at 102 (Herschel).

D-276. Betty Bybel refused Lithium through March, April, and May of 1975. Tr. 43 at 65, 66 (Schildkrout); Tr. 39 at 103 (Herschel); Pl. Ex. 7, Doc. Nos. 300715, 300716, 300716C.

D-277. Betty Bybel refused Lithium during the spring of 1975 because she did not want to get better. Tr. 43 at 65, 66 (Schildkrout).

D-278. There is evidence that Lithium, consistently taken, attenuates the extremities of manic-depressive illness, Tr. 63 at 14 (Myerson), and would be very helpful to Betty Bybel. Tr. 63 at 14 (Myerson); Tr. 65 at 75 (Gill).

D-279. Between January, 1973, and April, 1975, when Betty Bybel agreed to take and did take Lithium, she improved considerably. Tr. 65 at 72 (Gill); Tr. 39 at 101, 102 (Herschel).

D-280. When Betty Bybel took Lithium, her condition improved and she was able to be discharged:

a. After she began to take Lithium in December, 1973 (Pl. Ex. 7, Doc. No. 300192), she was discharged on January 5, 1974. Pl. Ex. 7, Doc. No. 300076.

b. After she began to take Lithium on January 20, 1974 (Pl. Ex. 7, Doc. No. 300698), and continued to take Lithium throughout February (Pl. Ex. 7, Doc. No. 300700), and March (Pl. Ex. 7, Doc. No. 300701), 1974, she improved and was able to be discharged on April 2, 1974. Pl. Ex. 7, Doc. No. 300217.

c. When she took Lithium throughout May (Pl. Ex. 7, Doc. No. 300704), and June (Pl. Ex. 7, Doc. No. 300707), 1974, she was discharged on July 9, 1974. Pl. Ex. 7, Doc. No. 300310.

D-281. During those periods between January, 1973, and April, 1975, when Betty Bybel was able to remain outside the hospital, she was taking Lithium. Tr. 40 at 102 (Herschel).

D-282. As Betty Bybel admitted, Lithium helped her in that when she was taking it, she did not get upset as easily as she had before taking it. Def. Ex. Z6, p.48 (Bybel).

D-283. Betty Bybel's failure to improve from January, 1973, through April 25, 1975, was substantially caused by her refusal to take Lithium. Tr. 65 at 75 (Gill); Pl. Ex. 7, Doc. No. 300263.

D-284. More probably than not Betty Bybel's condition would have improved in March and April, 1975, had she agreed to take and remain on Lithium during that period of time. Tr. 62 at 68 (Myerson).

D-285. Betty Bybel's seclusions in March and April, 1975, more probably that not would not have occurred had she agreed to remain on Lithium during that period of time. Tr. 62 at 68 (Myerson).

(IV.) *DAMAGES*

(A.) *Prognosis*

D-289. Betty Bybel's prognosis in January, 1973, when she was first admitted to the Austin Unit, was quite guarded. Tr. 65 at 71, 72 (Gill).

D-290. Betty Bybel, in January, 1973, was a very disturbed person with a history of prior disturbance, indicating that she may well have suffered from a chronic process that was becoming established. Tr. 65 at 71, 72 (Gill).

D-291. In December of 1973, the expected length of treatment for Betty Bybel was indeterminate, but staff members estimated that it would be approximately one to two years if she could "stick with therapy." Pl. Ex. 7, Doc. Nos. 300073A, 300073B.

D-292. As Betty Bybel's Austin Unit records reflect, she had difficulty "sticking with therapy." Pl. Ex. 7; Tr. 35 at 52 (Messinger).

D-293. In May of 1974, the expected length of treatment for Betty Bybel was approximately three to five years. Pl. Ex. 7, Doc. No. 300304A.

D-294. During the last winter and spring of 1975, Betty Bybel's prognosis was quite grave. This prognosis was based on the fact that Betty Bybel had a long history of psychiatric illness dating back to her first hospitalization is 1964; her behavior; her age; and the difficulty she had in engaging in therapy and in remaining in the hospital. There was not much hope that her condition would change over a long period of time. Tr. 43 at 63 (Schildkrout).

D-295. Betty Bybel's prognosis is very, very serious. Tr. 63 at 13, 14 (Myerson).

D-296. It is doubtful that Betty Bybel could ever be thought of as completely cured, given the psychiatric knowledge of her illness. Tr. 63 at 14 (Myerson).

(B.) *Medication Practices*

D-297. Betty Bybel suffered no permanent damages as the result of the medication practices of the Austin Unit during her hospitalizations from January, 1973, through April 25, 1975. Tr. 62 at 74 (Myerson).

D-298. Betty Bybel felt she received no permanent injury as the result of being involuntarily medicated at the Austin Unit. Def. Ex. Z6, p.63 (Bybel).

D-299. The only damage which Betty Bybel felt she received as the result of being involuntarily medicated at the Austin Unit were temporary lumps on her buttocks from the needle. Def. Ex. Z6, pp.63-64 (Bybel).

D-300. There is no expert testimony that the involuntary or forcible medication of Betty Bybel caused her to suffer any damage.

D-301. There is no expert testimony that Betty Bybel suffered any damage as the result of the medication practices at the Austin Unit. Plaintiffs' expert Messinger stated he was unable to form an opinion that Betty Bybel had suffered any damages as the result of the medication practices at the Austin Unit. Tr. 32 at 37, 38 (Messinger).

E. RUBY ROGERS

1. *Plaintiff's Proposed Findings of Fact and Defendants' Rebuttal**

(I.) RUBY ROGERS' BIOGRAPHICAL AND MEDICAL BACKGROUND

1.) Ruby Rogers born May 6, 1930, is a Black woman. She was first admitted to the May Unit in 1965 at the age of 28, because she claimed she "had sinned and must die." She was clinically depressed at that time. (Doc. No. 5000131.)

2.) She was born in Virginia and at the time of her admission to the hospital was living in Roxbury, Massachusetts. (Doc. No. 500001.)

3.) Prior to her admission to the May Unit of the Boston State Hospital, on January 16, 1973, she had been admitted to the hospital seven times beginning in October, 1965. (Doc. No. 500001.)

4.) One year prior to 1st admission, she became pregnant with her sixth child. In December, 1964, she began a relationship with an older woman who tried to "rehabilitate" Ruby. She became increasingly depressed and delivered a child in April 1965, which she placed for adoption. In September, 1965, her mother, who had visited her, went home, the other older woman left, and her boyfriend left. She developed paranoid ideation, increased depression and deterioration, sexual obsessions, hallucinations, and difficulty sleeping. (Doc. No. 500131.)

5.) She was the oldest of fourteen children. Her father died early of TB, so that eleven are half-siblings. She completed ninth grade, and had her first child at age 14, after which she came to Boston. She spent some time at Tewksbury State Hospital while pregnant, and claims this to be a happy period. She then worked at Boston City Hospital. She began a relationship with an older man which lasted several years, and who fathered two children of her. (Doc. No. 500131)

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* Defendants' Rebuttals are designated "DR"

6.) Her initial admitting diagnosis was schizophrenia with depressive features. At times, a schizo-affective diagnosis has been entertained. Her hospital courses have been characterized by gross delusional material, hallucinations, depression, and withdrawal. (Doc. No. 500131)

DR-6.) "[Rubie Rogers'] hospital courses have been characterized by gross delusional material, hallucinations, depression, withdrawal with other periods of aggressiveness towards others." Pl. Ex. 9, Doc. No. 500139.

7.) The following contain descriptions of Ruby Rogers' mental state while a patient in the May Unit from January 1, 1973 to April 30, 1975:

a.) Simple undifferentiated schizophrenia-impression at admission. (Doc. No. 500001.)

b.) Schizophrenia, paranoid type — established diagnosis. (Doc. No. 500001.)

c.) Anti-social personality — established diagnosis. (Doc. No. 500001.)

d.) Schizophrenic, chronic, undifferentiated. (Doc. No. 500003.)

e.) Thought disorder and bizarre behavior. (Doc. No. 500009.)

f.) Reaction, schizophrenia type (affective type). (Doc. No. 500025.)

g.) Chronic Schizophrenia (Doc. No. 500056.) (Stip. p. A232.)

8.) Ruby Rogers is an example of the revolving door, par excellance. Much more has to be done to prepare her for life outside the institution. (P-Messinger TR. 31-69.)

9.) The following summary shows the admission status of Ruby Rogers in the May Unit from January 1, 1973 to April 30, 1975:

a.) On January 16, 1973, she was discharged for a visit. (Doc. No. 500002.)

b.) On January 17, 1973, she returned. (Doc. No. 500002.)

c.) On January 31, 1973, she was discharged for a visit. (Doc. No. 500002.)

d.) On February 1, 1973, she returned. (Doc. No. 500002.)

e.) On February 5, 1973, she was discharged for an extended visit. (Doc. Nos. 500002, 500003, 500004.)

f.) On September 12, 1973, she returned. (Doc No. 500002.)

g.) On September 17, 1973, she escaped. (Doc. No. 500002.)

h.) On September 19, 1973, she returned. (Doc. No. 500002.)

i.) On October 14, 1973, she left without permission. (Doc. No. 500002.)

j.) On October 15, 1973, she returned. (Doc. No. 500002.)

k.) On October 20, 1973, she left without permission. (Doc. No. 500002.)

l.) On October 21, 1973, she returned. (Doc. No. 500002.)

m.) On February 8, 1974, she left without permission. (Doc. No. 500002.)

n.) On February 14, 1974, she returned. (Doc. No. 500002.)

o.) On November 8, 1974, she was discharged for an extended visit. (Doc. No. 500002.)

p.) On November 23, 1974, she returned. (Doc. No. 500002.)

q.) On March 7, 1975, she left without permission. (Doc. No. 500002.)

r.) On March 9, 1975, she returned. (Doc. No. 500002.)

s.) On March 11, 1975, she was transferred to the Shattuck Hospital for medical care. (Doc. No. 500054.)

t.) On March 28, 1975, she returned to the May Unit. (Doc. No. 500002.)

u.) On April 30, 1975, she was held at the May Unit. (Stip. pp. A231-232.)

10.) On many occasions, Ruby Rogers from '73 to September, 1974 would leave the hospital and be placed on an AWA status. She was not considered to be a serious risk at that time, and she was allowed to stay away at her option. (D-*KAHN* TR. 50-159.)

DR-10.) Dr. Kahn did not testify that from 1973 to September, 1974, Rubie Rogers was not considered to be a serious risk and she was allowed to stay away from the hospital at her option. He merely testified that on many occasions when she was not considered a serious risk or risk of being in such precarious health that she would disintegrate in the community, she was able to leave the hospital under the May Unit's AWA policy. Tr. 60 at 159 (Kahn).

11.) Ruby Rogers was never committed by any court to the May Unit between January, 1973 and May, 1975. (TR. 27-93; Stip. pp. A231-237.)

12.) In May of 1975, she indicated to him that she wished to receive no further treatment at the institution. (D-*CACCIOLA* TR. 56-45.)

13.) She was not presently considered by the staff to be a danger to herself or to other. She refused treatment. (D-*CACCIOLA* TR. 56-47.)

14.) The May Unit treating staff considered Ruby Rogers' dependency on the hospital and her anxiety about leaving the hospital and being out on her own as the major treatment problem during the period in question. (P-Messinger, TR. 31-7.)

DR-14.) The May Unit treating staff considered Rubie Rogers' major treatment problem to be her refusal of treatment in the face of a history of unrelenting psychosis and periods of self-destructiveness and of assaults upon others. Pl. Ex. 9, Doc. Nos. 500010, 500139, 500139A, 500051A.

15.) The May Unit treatment staff saw Ruby Rogers as overly dependent in a regressed state and excessively passive in her relationship to others. (P-Messinger TR. 31-7.)

DR-15.) The May Unit treatment staff saw Rubie Rogers *not* as exclusively passive in her relationship to others, but as frequently hostile, belligerent, aggressive, and assaultive to others. Pl. Ex. 9, Doc. Nos. 500139-100139A. See also Defendants' Proposed Findings G-17-G-20.

16.) "At this point she represents somewhat of a therapeutic impasse. On interview she is extremely restless, flagrantly deluded, talking about the need to get out of here and go to Tewksbury Hospital (where she had her children) because 'rats are eating my feet.' Attempts to follow this delusional train of thought down were unsuccessful. She was aggressive, saying 'you're no doctor.' She mumbled about how she could trust this one and that one in the audience but was distractable, sullen, and confused. Eventually she left the interview only to come back a little bit later again to leave. She has improved before after long periods of stay. It seems important to try to tease out of her voluminous record how that improvement was effected, especially with the aid of whom. I suspect that it is possible to get into a relationship with her, though the tenuous sort and only after must testing. It seemed at the conference that the wise thing to do was to try to get her involved with one therapist. A man may succeed somewhat more easily. Her deepest longings and deepest fears seem to be of a woman, and it may be possible to have a more realistic relationship with her sooner if this is not a strong immediate issue. Diagnosis: Schizophrenia, paranoid type." (Doc. No. 500010, dated November 19, 1973, signed by Peter Knapp, TR. 31-8, 9, and 10.)

17.) One of the goals of the treatment team plan for Ruby Rogers during this period was to develop a sense of autonomy, competency and ability to critically examine one's own

behavior and to help her to achieve a sense of self as an independent and initiating person. (P-Messinger TR. 31-11.)

18.) The note from November of 1973, Doc. No. 500010, written by Dr. Peter Napper, referring to a "therapeutic impasse," is a situation where it is difficult for the patient to establish a therapeutic relationship. She has, in a sense, walled herself off so that she cannot trust anybody. (D-Myerson, TR. 62-77.)

19.) Rubie Rogers had an inordinate wish to be left alone. (D-Myerson TR. 63-48.)

(III.) *RUBY ROGERS' ASSAULT AND BATTERY CLAIMS AGAINST THE DEFENDANTS KAHN, CACCIOLA, OSBORNE AND MALAMUD*

(A .) *The involuntary use of medication upon the Plantiff Ruby Rogers was not privileged since it was used where an emergency as defined by M.G.L. c.123 §§1, 21 did not exist.*

90f.) Prior to April 30, 1975, doctors ordered or authorized the forcible or involuntary medication of incompetent but non-court adjudicated incompetent patients in non-emergency situations, without attempting to petition a course of competent jurisdiction for an appointment of a guardian. (D-*OSBORNE, KAHN, KANTAR, MALAMUD, SCHILDKROUT, SEIL, SEIGEL, GILL, TURNQUEST, SZLYK* 1st Set of Admissions, No. 74. D-*KANTAR* TR. 12-114,115.)

DR-90f.) There is no testimony that Rubie Rogers was incompetent between January, 1973, and April 30, 1975.

91.) Between January 1, 1973 and April 30, 1975, medication was prescribed for the treatment of Ruby Rogers in at least the total daily amounts, and for the periods described in the following attachments. (Stipulations, for Ruby Rogers, pages A234-A257.)

92.) The following documents describe some of Ruby Rogers' medication:

Document	*Order*	*Dr.*	*Date*	*Medication*
Doc. Nos. 500059, 500058	PO or IM	Sydney	9/13/73	15mg. Haldol BID 5 mg. IM
Doc. No. 500044	PO	Sydney	11/16/73	23 mg. Haldol
Doc. No. 500122	IM		11/12, 17, & 21/73	15 mg. Haldol (PRN)
Doc. No. 500043	PO or IM	Sydney	10/28/73	20 mg. Haldol 10 mg. Haldol (IM)
Doc. Nos. 500048 500127	PO		6/3/74	20 mg. Haldol
Doc. No. 500050	PO or IM		7/15/74	5 mg. Haldol PO or IM PRN
Doc. Nos. 500132 500055	IM		11/23/74	5 mg. Haldol PRN

(Stipulations for Ruby Rogers, page A234.)

93.) The medical records of Ruby Rogers do not note:

a. Why medication orders were not renewed every 30 days;

b. Why Ruby Rogers was prescribed and administered different phenothiazines simultaneously;

c. Reasons for changing type of prescribed medication from one phenothiazine to another;

d. Whether medication was given with the informed consent of Ruby Rogers;

e. Specific guidelines describing the circumstances in which the May Unit staff was authorized to use the medication as a chemical restraint;

f. Specific guidelines describing the circumstances in which the May Unit staff was authorized to use PRN medication.

Stipulations for Ruby Rogers, pages A234 - A235.)

DR-93.) From January 1, 1973, through April, 1975, Rubie Rogers was not prescribed and administered different phenothiazines simultaneously. Plaintiffs' Proposed Finding No. 91.

94.) There were innumerable times when Ruby Rogers refused to take her medication. (D-*CACCIOLA* TR. 56-45.)

DR-94.) Dr. Cacciola also testified that if Rubie Rogers was in reasonable control, he honored her request to refuse medications. Tr. 56 at 45 (Cacciola).

95.) Ruby Rogers asked Dr. Cacciola to change her medication but he wouldn't listen to her. (P-*ROGERS* TR. 28-21.)

96.) Ruby Rogers refused to take Haldol once she began to feel symptoms that she considered to be side effects of that medication. (P-*ROGERS* TR. 28-22.)

DR-96.) Rubie Rogers testified that she took Haldol only ten or fifteen times when she didn't want it. Tr. 28 at 36 (Rogers).

97.) In Dr. Cacciola's opinion, Ruby Rogers did not seem capable of conversing with anyone on the point with regards to the use of medication; did not seem to be able to make rational decisions about the benefits and risks of her medication. (D-*CACCIOLA* TR. 55-66.)

98.) One of the complaints that Ruby Rogers discussed with Dr. Cacciola was medication. (D-*CACCIOLA* TR. 56-64.)

99.) Dr. Cacciola "would not have been surprised" if Ruby Rogers had side effects during that period. (D-*CACCIOLA* TR. 56-65.)

DR-99.) After Rubie Rogers complained to Dr. Cacciola about her medications, he evaluated her to see if she was receiving side-effects from the medication she was receiving and observed no symptoms in her of drug-induced side-effects. Tr. [illegible] at 43 (Cacciola).

100.) No one ever explained the side effects of taking Haldol to Ruby Rogers. (P-*ROGERS* TR. 28-9.)

DR-100.) As Rubie Rogers testified, Mrs. Ford explained to her that Haldol might cause certain side-effects. Tr. 28 at 13 (Rogers). See also, Defendants' Proposed Findings G-84, G-85, G-87.

100a.) Prior to April 30, 1975, the doctors at time did not inform their patients who were medicated as part of a planned therapeutic program of the effect, side effects, and risks of the proposed medication. (D-*GOLDBARG, OSBORNE* First Set of Admissions #47.)

101.) Ruby Rogers on a number of occasions had tried to take medication in the hopes it would get her out of the hospital. (P-*ROGERS* TR. 28-9.)

102.) Ruby Rogers remembered feeling really sick shortly after taking Haldol for the first time; that it closed up her throat and interfered with her ability to sleep, made her very thirsty and it interfered with her appetite making her nauseous. (P-*ROGERS* TR. 28-9,10.)

103.) Ruby Rogers also felt stiffness in her lower back, in her hand and feet. (P-*ROGERS* TR. 28-10.)

104.) Dr. Cacciola remembered an incident where Ruby Rogers was given intramuscular medication against her will. (D-*CACCIOLA* TR. 56-41.)

DR-104.) On this occasion Rubie Rogers was very agitated, threatening people, and staff were very concerned about her attacking someone. In fact, when Dr. Cacciola tried to speak with her, she attacked him. Tr. 56 at 41, 42 (Cacciola).

105.) Ruby Rogers was administered the needle when she received medication forcibly in her buttocks. (P-*ROGERS* TR. 28-25; 27-99.)

DR-105-107.) See Defendants' Proposed Findings G-169. As Rubie Rogers' records reflect, she received antipsychotic medication by intramuscular injection on

only ten days between January 1, 1973, and April 25, 1975. Pl. Ex. 9, Doc. Nos. 500059, 500127, 500132.

Seven of those dates were in September, 1973, when she was in and out of seclusion for out of control behavior and was escaping from the hospital. Pl. Ex. 9, Doc. No. 500062, 500065, 500067, 500074, 500071. She was given a PRN of 10 mg. Haldol IM, on June 21, 1974, when she was secluded following the fire on her ward. Pl. Ex. 9, Doc. Nos. 500127, 500094. She received PRN Haldol, 5 mg. I.M. on November 23 and 24, 1974, after she had been returned to the hospital by police after breaking into a building. Pl. Ex. 9, Doc. Nos. 500132, 500029.

The administration of antipsychotic medications intramuscularly do not tear the buttocks or leave knots in the buttocks lasting two to three months. Tr. 60 at 168, 169 (Kahn).

106.) Ruby Rogers remembers the experience of being forcibly medicated with a needle involving bleeding a lot as if they were ripping her. She felt as if she were being punished; as if the needle was pulled across her buttocks. Knots would be left for several months after she would receive the needle. (P-*ROGERS* TR. 28-25.)

107.) The above occurrence happened quite a few times but she couldn't remember how many. (P-*ROGERS* TR. 28-25.)

108.) Ruby Rogers remembered times when she took medication orally but didn't really want it. (P-*ROGERS* TR. 28-26.)

DR-108.) See Defendants' Response to Plaintiffs' Proposed Finding 96, above. Rubie Rogers also testified that everytime she refused her medication, she was given the needle. Tr. 28 at 24 (Rogers). See Defendants' Response to Plaintiffs' Proposed Findings Nos. 105-107, above.

109.) Ruby Rogers would take the medication orally because she did not want to be secluded and she didn't want to receive the needle. (P-*ROGERS* TR. 28-26.)

109a.) It was a general practice to inform patients that if they didn't take their medication they would receive it through a hypodermic needle. (P-*ROGERS* TR. 28-22,23,24,25,26. P-Keller TR. 28-90, line 25; 28-91. P-Franceen Tr. 20-45,46,47,48,49,50; 20-53, lines 22-25; 20-54, line 1. P-Cariello TR. 22-7,8,10,11,12; 22-14, lines 12-25; 22-15, lines 1-3.)

DR-109a.) Plaintiffs' witnesses Franseen and Cariello were not employed at the May Unit where Rubie Rogers was a patient. Tr. 20 at 42 (Franseen); Tr. 22 at 2 (Cariello). See also Defendants' Proposed Findings G-175.

110.) Prior to the filing of the law suit, Ruby Rogers was never told that she had the right not to take the medication if she didn't want it. (P-*ROGERS* TR. 28-26,27.)

111.) After the law suit was filed, Ruby Rogers was given the right to refuse medication. (P-*ROGERS* TR. 28-24.)

112.) In the discussion that Ruby Rogers had with Dr. Seil after the law suit regarding her medication, she complained about the side effects. (P-*ROGERS* TR. 28-18,19. D-*SEIL* TR. 58-10.)

112a.) It was the general policy and practice to medicate patients forcibly or involuntarily with antipsychotics when there was not a serious threat of or as a result of extreme violence, personal injury or attempted suicide. (D-*SEIL* TR. 58-61, lines 12-19. See Proposed Findings #194-210.)

DR-112a.) Dr. Seil testified that patients were not forcibly or involuntarily medicated at the May Unit in any situation other than when the patient was acutely ill and in a state of psychiatric emergency. Tr. 58 at 22 (Seil).

112b.) Prior to the issuance of the temporary restraining order, medication was used involuntarily in non-emergencies as part of a planned psychotherapeutic program. (D-*SEIL* TR. 58-72, lines 1-7; 58-72, lines 17-22. D-*GILL* TR. 11-148; 11-149. See also Proposed Findings #194-211.)

DR-112b.) Dr. Gill was not employed at the May Unit where Rubie Rogers was a patient. See Defendants' Proposed Finding B-9; G-191-G-194.

112c.) As a policy and practice, the doctors would make a substitute decision, and order that the patient be involuntarily or forcibly medicated when the doctor believed that the patient was in discomfort or anguish that was unnecessary or unacceptable, and the patient did not feel the medication was in his/her best interest. (D-*KANTAR* TR. 11-160, lines 4-12. D-*GILL* TR. 64-53; 64-54. D-*MAZMANIAN* TR. 49-30, lines 10-25; 49-31; 49-32.)

DR-112c.) Dr. Kantar and Dr. Gill were not employed at the May Unit where Rubie Rogers was a patient. See Defendants' Proposed Findings B-12, B-9; G-174, G-175, G-79-G-95.

113.) After the law suit, Dr. Seil changed Ruby Rogers' medication from Haldol to Moban. (P-*ROGERS* TR. 18-18. D-*SEIL* TR. 58-11.)

114.) Dr. Seil says that Ruby complained a great deal about her medication. It was during a period in which she was having the most difficulty cooperating with the staff. The change in medication occurred when she expressed some cooperation in going on regular therapeutic medication. (D-*SEIL* TR. 58-10.)

115.) Dr. Seil did not recall Mrs. Rogers complaining about side effects of Moban. (D-*SEIL* TR. 58-12.)

116.) At first Ruby Rogers voluntarily took the Moban because it felt good and seemed to be doing alright. (P-*ROGERS* TR. 28-19.)

DR-116.) Rubie Rogers also testified that within two to three months, the side-effects of Moban developed and she began to refuse this medication. Tr. 28 at 19 (Rogers). In fact, it does not take two to three months for the side-effects of Moban to take effect. The side-effects of Moban should take effect relatively rapidly — within 48 hours of initial administration. Tr. 58 at 11, 12 (Seil).

117.) Subsequent to taking both Haldol and Moban, Ruby Rogers voluntarily also took Mellaril prescribed as an outpatient for her. (P-*ROGERS* TR. 28-20.)

DR-117.) Rubie Rogers anticipated, however, that she would develop "side-effects" from the Mellaril, as well. Tr. 28 at 21 (Rogers).

118.) In the spring of 1975, Dr. Seil considered Ruby Rogers to be in a state of psychiatric emergency. (D-*SEIL* TR. 58-23.)

DR-118.) Dr. Seil considered Rubie Rogers' behavior to constitute a threat of personal injury to herself or others at times during the spring of 1975. Tr. 58 at 23 (Seil).

119.) When she came back from the Shattuck she was voluntarily taking the medication. (D-*SEIL* TR. 58-96.)

DR-119.) This was after the issuance of the temporary restraining order. Tr. 58 at 95 (Seil).

120. According to Dr. Seil, Ruby Rogers had a lot of difficulties with Haldol. The Haldol had caused her to experience serious side effects. She had by this time built up an antipathy to Haldol; and, that to continue Haldol would only cause further problems with treating her effectively. (D-*SEIL* TR. 58-96.)

DR-120.) Dr. Seil did not testify that Haldol caused Rubie Rogers to experience serious side-effects. Dr. Seil's testimony was that Rubie Rogers had a lot of difficulties with many other medications and that she had built up an antipathy to Haldol, that she just had a feeling about that drug by that time, which was after the issuance of the temporary restraining order. Tr. 58 at 96 (Seil).

121.) The difficulty was in her cooperation in the treatment plan regardless of what side effects she had. "She just had a feeling about the drug by that time. It would not help us working with her to keep her on it, even if she did tolerate it well. She agreed that she was looking for a drug that she was willing to take, that would not cause serious side effects." (D-*SEIL* TR. 58-96,97.)

DR-121.) Dr. Seil did not state, "She agreed that she was looking for a drug that she was willing to take, that would not cause serious side effects." Tr. 58 at 96, 97 (Seil).

(IV.) *RUBY ROGERS' MEDICATION MALPRACTICE CLAIMS AGAINST THE DEFENDANTS KAHN, MALAMUD, OSBORNE AND CACCIOLA*

(A.) The Medication of Ruby Rogers Involuntarily Without Her Informed Consent Was Unacceptable Medical Practice.

* * *

124.) Mrs. Rogers described a number of very distressing, subjective complaints, symptoms, bodily symptoms which she attributed directly to the medication. She did not have them before she took the medication. She did not have them when the medication was stopped and when it was reinstituted she again had them. She described an active sense of discomfort physically. She felt fidgety and restless. She felt ill. It affected her eating pattern in that she was eating more slowly. She said she experienced a trembling sensation in her feet as if something were crawling in them but it was a tactile sensation in the soles of her feel which could be described medically as paresthesia. Ruby Rogers sustained harm in a variety of ways because of the refusal of the medical staff to respond to her complaints about the medication she was receiving. This refusal undermines any therapeutic alliance when a patient expresses distress to the staff or therapist and this is not responded to in an inquiring and sympathetic manner. The actual experience is distressing and discomforting. And third, in terms of reality testing which means consensual validation of outside experience it also means correct reading of one's internal subjective experience both emotional and physical. The staff's unresponsiveness to these complaints is like an invalidation of her internal experience and can be extremely disturbing to any human being particularly one who is having problems in the area of reality testing. (P-Messinger TR. 31-56,57.)

DR-124.) Many of Rubie Rogers subjective complaints were not side-effects and were not caused by antipsychotic medications. See Defendants' Proposed Findings G-150-G-154, G-12-G-16. The medical staff of the May Unit did respond to her complaints. See Defendants' Proposed Findings G-98-G-110, G-163. Rubie Rogers' feelings as if something were crawling in her feet were not paresthesia; they were not side-effects and were not caused by antipsychotic medications. See Defendants' Proposed Findings G-155-G-158.

126.) A person is demeaned and humiliated often times in a public setting and exposed physically and treated at best as if one were a child. That has a countertherapeutic effect. (P-Messinger TR. 31-58.)

127.) Involuntary and forcible medication should only be used as a last resort. Medication should be used as a restraining mechanism only if a patient were actually physically assaultive to others. (P-Messinger TR. 31-60.)

128.) The involuntary medication by the May Unit between January, 1973 and May of 1975 of Ruby Rogers during non-emergency situations was antitherapeutic for her in that it lessened the likelihood of her developing the necessary self-sufficiency to be able to stay out of the institution. This involuntary medication of Ruby Rogers was a substantially contributing factor to slowing down the process of helping her stay out of the hospital. (P-Messinger TR. 31-71.)

DR-128.) See Defendants' Proposed Findings G-146, G-147. If the physicians of the May Unit had not given antipsychotic medication to Rubie Rogers, she still would have required subsequent hospitalization and still would be in outpatient mental health care today. Tr. 35 at 3 (Messinger).

129.) Ruby Rogers was observed by her medical staff in the May Unit at one time or another between January, 1973 and April, 1975 as suffering from the following side effects of the medication she was receiving from them: stiffness, the shakes, fatigue, and anoretic and immobilized condition, due to a lack

of energy and weakness, neutropenia, which is a decrease in the white blood count. (P-Messinger TR. 31-73,74,75,76. Doc. No. 500030.)

DR-129.) See Defendants' Proposed Findings G-150-G-164. The stiffness and shakes experienced by Rubie Rogers were not side-effects of the medication she was receiving. Pl. Ex. 9, Doc. No. 500003. Rubie Rogers was treated for neutropenia, causing her to be in an anoretic and immobilized condition, prior to January, 1973, in December, 1972. Pl. Ex. 9, Doc. Nos. 500003, 500153-500157.

130.) Other side effects recorded by the medical staff included restlessness, frequent pumping motions of legs while sitting in which excessive fatigue was associated. (P-Messinger 31-76,77. Doc. No. 500019, dated 8/14/74.)

DR-130.) Following the appearance of these symptoms, the physicians of the May Unit prescribed Cogentin for Rubie Rogers, causing her to be more relaxed. Pl. Ex. 9, Doc. No. 500019. As Dr. Messinger testified, this was the appropriate and acceptable response. Tr. 31 at 77 (Messinger).

131.) The side effects from Mrs. Rogers could reasonably have been related to the medication, Haldol she was receiving. (P-Messinger TR. 31-79. See also Doc. No. 500031 regarding akathisia and muscle stiffness related to Ruby Rogers taking Haldol.)

136.) The failure to change the medication caused the white blood count to go down to a level of 2500 which is a dangerously low level in order for the body to protect against bacterial infection. (P-Messinger TR. 31-84,85.)

DR-136-139.) See Defendants' Proposed Findings G-170. Rubie Rogers did not receive two psychotropic medications simultaneously between January 1, 1973, and May 1975. Plaintiffs' Proposed Finding No. 91.

137.) Neutropenia was caused by the failure to change either prolixin or the haldol or combination of the two that was being prescribed by the May Unit staff at the time. (P-Messinger TR. 31-86).

138.) Mrs. Rogers suffered damage when she suffered from the neutropenia. (P-Messinger TR. 31-87.)

139.) By using two psychotropic medications such as haldol and prolixin as in the case of Ruby Rogers, one increases the risks of toxicity and adverse effects. (P-Messinger TR. 31-88; see also 31-88,89, with regards to relating the side effects that Ruby Rogers complained about with the haldol.)

140.) Discussions with Mrs. Rogers in conjunction with the reading of her medical record support the opinion that the side effects about which she complained were related to her taking the haldol. (P-Messinger TR. 31-89.)

144.) Ruby Rogers suffered from motor restlessness defined as akathisia, and a sense of immobility defined as akinesia. (P-Messinger TR. 31-92.)

145.) The use of any psychotic agents particularly in higher doses leads to slowing of the thought processes, clouded consciousness, impairment in reasoning, impaired memory, and impaired learning. (P-Messinger TR. 31-95, 96.)

146.) Prescription of antipsychotic medication will cause a slowing of the thought processes and in general will reduce initiative and cause more passivity in patients. (P-Messinger TR. 31-96.)

147.) The reception of antipsychotic medication will have a general dampening effect on the patient's spontaneity and on the motivation of the patient. Patients often complain of feeling robot-like. (P-Messinger TR. 31-96.)

148.) The antipsychotic medication received by Ruby Rogers between January, 1973 and May, 1975 affected her spontaneity and motivation. (P-Messinger TR. 31-96, 97.)

149.) The medication Ruby Rogers was receiving during this period would have an effect on her motivation to leave the hospital by lessening that motivation. (P-Messinger TR. 31-98.)

150.) It would lessen her capacity to do the planning and preparation for making that step. (P-Messinger TR. 31-98.)

151.) Psychotic individuals are not uniformly impaired in all aspects of their personality functions, or more technically speaking ego-functioning, and although by definition their relationship to reality is impaired, there are some aspects of reality which they can accurately assess; that is, there are very few individuals who are so flagrantly and completely psychotic that they can't understand any aspect of their relationship with their environment. (P-Messinger TR. 31-99.)

(B.) *Ruby Rogers Was Harmed By The Defendants' Medication Practices.*

154.) Nausea constitutes a side effect of the antipsychotic medication that Mrs. Rogers was receiving. (D-Meyerson TR. 63-31.)

DR-154-155.) Rubie Rogers did not experience merely nausea and vomiting, but a fever as well. Tr. 28 at 101 (Rogers). Dr. Myerson did not testify that Rubie Rogers experience nausea that was caused by the antipsychotic medication she was receiving. See Defendants' Proposed Findings G-159-G-161.

155.) Haldol produces, occasionally, nausea and vomiting as side effects. (D-*KAHN* Tr. 60-170.)

156.) Ruby Rogers' whole body sometimes would quiver. (P-*ROGERS* TR. 28-16.) This feeling stayed with her the entire time she was on the Haldol in the hospital. (P-*ROGERS* TR. 28-16.)

157.) Ruby Rogers experienced stiffness as long as she took her medication. (P-*ROGERS* TR. 28-16.)

158.) Ruby Rogers felt stiffness in her lower back, in her hands, and in her feet, and would break out in cold sweats in what appeared to be side effects related to her taking the Haldol. (P-*ROGERS* TR. 28-12. See also Doc. No. 500031.)

159.) In the hospital she responded very well to the same meds she had been on as an out-patient: Haldol 5 mg. po QID; Prolixin Enanthate 1.5 cc IM q 2 weeks. It had originally been postulated that the stiffness and "shakes" that she had de-

scribed PTA might be due to the extrapyramidal effects of Prolixin; yet she was given her usual injection on admission and no cogentin; the stiffness disappeared within 6 days. It should also be noted that when the patient was told she would be leaving the hospital soon, she began to complain of the same stiffness and, in fact, at this time was not on any Prolixin.

Besides this above-mentioned complaint, the patient was fatigued, anoretic and was completely immobilized, due to lack of energy and weakness. She was worked up medically for this, and it was discovered that she had a neuropenia of 2,800. The patient was subsequently transferred to the D Bldg., where it was postulated on hematology consult that the neuropenia was drug-induced. All meds were subsequently stopped and within 3 weeks, her WBC had returned to her normal range of 5,000. At that time Haldol was started again at 5 mg. BID, because it has a much less chance of causing blood dyscrasias than do the phenothiazines. (Doc. No. 500003, dated February 7, 1973.

160.) The patient was begun on a course of Haldol 10 mgs. po bid to be increased as necessary, initially requiring seclusion. She received frequent CBCs for it has been noted that while on Thorazine in the past, she developed a neuropenia of alarming degree; however, her white count in here has been normal. (Doc. No. 500004, dated September 12, 1973.)

161.) Haldol might have caused "akathisia" which is, among other things, a restlessness of the legs. (D-*KAHN* Tr. 60-170, 171.)

DR-161.) Akathisia is usually quite responsive to anti-Parkinsonian medication, which was prescribed for Rubie Rogers. Tr. 60 at 170, 171 (Kahn).

Dr. Kahn also testified that "sensory signs from Haldol . . . are quite rare," and that "Haldol, more probably than not, did not produce the feeling of rats crawling and biting Rubie Rogers' feet." Tr. 60 at 170 (Kahn).

162.) "Her general state, however, improved on larger doses of Haldol. Cogentin was required as a result of extra peramital (sic) reactions including akathisia." (Doc. No. 500026, dated November 8, 1974.)

163.) "On Haldol 50 mgm. h.s., because of complaints of restlessness and frequent pumping motion of legs, while sitting, in addition to excessive fatigue, placed on Cogentin, mgm bid". (Doc. No. 500019, dated 8/14/74.)

164.) "Haldol increased because increasing complaints of greater nervousness—confirmed by her appearance . . . . . 7/23/74 Feeling tired and groggy during daytime—will change Haldol to 10 mgm. q. a.m. and 40c. H.S." (Doc. No. 500018.)

(V). *THE DEFENDANTS OSBORNE, CACCIOLA, MALAMUD, KAHN, WERE AWARE OF OR INTENTIONALLY OR RECKLESSLY AVOIDED THEIR RESPONSIBILITY TO BE INFORMED THAT MEDICATION WAS BEING USED UPON RUBY ROGERS INVOLUNTARILY UNDER CIRCUMSTANCES WHERE IT WAS NOT PRIVILEGED AS AN EMERGENCY PURSUANT TO M.G.L. c. 123, §21.*

(1) *EACH OF THE FOLLOWING DEFENDANTS WAS KNOWINGLY AND INTENTIONALLY RESPONSIBLE FOR THE INVOLUNTARY MEDICATION FOR RUBY ROGERS.*

(A) *Dr. CACCIOLA's Responsibility for the Medication of Ruby Rogers.*

165.) Dr. *CACCIOLA* was a psychiatric resident on May 4 from January, 1975 to June, 1975 and was responsible for the psychiatric care of in-patients on May 4. His responsibility included planning treatment and discussing and deciding how

patients who presented problems would be managed. He was also responsible for the prescription of medications and seclusions on May 4. (D-*CACCIOLA* Tr. 56-7, 56-27, 56-29; D-*OSBORNE*-TR. 34-55, 56, 57.

166.) Dr. *CACCIOLA* ordered and authorized the medication that Ruby Rogers received between January, 1975 and April 30, 1975. (Doc. No. 500056. See Proposed Findings for Ruby Rogers for January through April, 1975.)

167.) Dr. *CACCIOLA* remembers speaking with Ruby Rogers about once a week with regards to the medication she was receiving. (CACCIOLA-TR. 56-38.)

168.) Dr. *CACCIOLA* was not aware of a unit wide policy which regards the using of forced medication when a patient refused in the May Unit when he was there. (D-*CACCIOLA*-TR. 56-58.)

169.) He learned the use of medication and seclusion from within a medical model, that when one learns medicine one learned that one has to evaluate every particular situation and figure out what treatment is going to be either most appropriate or most helpful in that situation. That's really how he learned to use medication and seclusion, not by reading laws. (D-*CACCIOLA*-TR. 56-59.)

2. Defendants' Proposed Findings of Fact and Plaintiffs' Rebuttal*

RUBIE ROGERS—MALPRACTICE AND CIVIL RIGHTS CLAIMS

(I.) *HER ILLNESS*

(A.) *History of Prior Hospitalizations*

G-1. Rubie Rogers had a history of multiple admissions to the May Unit, dating back to 1965. Plaintiffs' Ex. 9, Doc. No. 500001.

G-2. Certain staff members at the May Unit had known Rubie Rogers since the mid-60's, when she was first a patient at the May Unit. Tr. 68 at 122 (Ford).

(B.) *Diagnosis*

G-3. Rubie Rogers has been diagnosed as having chronic schizophrenia. Plaintiffs' Ex. 9, Doc. Nos. 500115, 500010, 500031, 500027A, 500004A, 500025, 500026, 500004, 500004A, 500020A, 500020, 500027.

(C.) *Symptoms-Thought Disorder*

G-4. Rubie Rogers had a thought disorder. See, e.g., Plaintiffs' Ex. 9, Doc. Nos. 500009A, 500009C, 500009F.

G-5. Rubie Rogers experienced visual and auditory hallucinations, including voices telling her to kill herself. Plaintiffs' Ex. 9, Doc. No. 500003.

G-6. Rubie Rogers experienced numerous delusions, including the delusion that rats were crawling and biting in her feet, (Tr. 68 at 127 (Ford); (Plaintiffs' Ex. 9, Doc. Nos. 500010, 500006, 500009A, 500009D, 500009F), that rats and cats were down her throat (Plaintiffs' Ex. 9, Doc. No. 500115), and that she was being bitten by snakes. (Plaintiffs' Ex. 9, Doc. No. 500009A).

G-7. Rubie Rogers experienced delusions that urine had been placed in her water (Tr. 27 at 103 [Rogers]) and that mucus had been placed in her food (Tr. 27 at 109 [Rogers]).

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*Plaintiffs' Rebuttals are designated "PR"

G-8. These beliefs that urine had been placed in her water and mucus in her food constituted a misperception that was caused by her mental illness. Tr. 58 at 17 (Seil); Tr. 63 at 39, 40, 42 (Myerson). It is not an uncommon symptom of schizophrenia to believe that food is poisoned, altered, or tampered with by such substances as urine or feces. Tr. 63 at 40 (Myerson).

G-9. Rubie Rogers experienced the delusion that dirt on the floor burned her feet. Tr. 27 at 107 (Rogers).

G-10. This perception that her feet were burned was caused by her schizophrenia, not by dirt on the floor. Tr. 63 at 42 (Myerson).

G-11. Rubie Rogers experienced delusions that others were going to attack her physically or kill her (Plaintiffs' Ex. 9, Doc. No. 500139); that people were poisoning her; that people were against her; that people were influencing and affecting her by giving her medications; and that people were locking her in the May Unit and not letting her go. Tr. 56 at 38 (Cacciola).

D. *Symptoms-Somatic Delusions*

G-12. Rubie Rogers had numerous somatic complaints. Tr. 68 at 136 (Ford); Plaintiffs' Ex. 9, Doc. Nos. 500029, 500010, 500003, 500009C, 500009D.

G-13. Rubie Rogers had multiple somatic delusions; that is, she felt that there were things wrong with her body when in fact there was nothing wrong with her body. Tr. 63 at 35 (Myerson); Plaintiffs' Ex. 9, Doc. No. 500010.

G-14. The feeling that a rat was biting her feet was a somatic delusion. Tr. 63 at 35 (Myerson).

G-15. At times when Rubie Rogers' complaints of illness were investigated, she was found to have no medical problems. Plaintiffs' Ex. 9, Doc. Nos. 500004A, 500161, 500163, 500013.

G-16. Even after a determination was made that she had no medical problems (Plaintiffs' Ex. 9, Doc. Nos. 500004A,

500164), Rubie Rogers continued to complain of physical ailments. Plaintiffs' Ex. 10, Entries No. 15, 16, 17.

E. *Symptoms-Assaultive Behavior*

G-17. When a patient at the May Unit, Rubie Rogers at times physically attacked other patients and staff members and threatened patients and staff members with physical harm. Plaintiffs' Ex. 9, Doc. Nos. 500007, 500026, 500031, 500033, 500062, 500065, 500091, 500139; Plaintiffs' Ex. 10, Entries No. 29, 34, 55, 57.

G-18. On one occasion Rubie Rogers attacked Dr. Cacciola. At that time she was extremely agitated, threatening people, and unable to discuss her situation with him. Tr. 56 at 44, 42 (Cacciola)

G-19. The May Unit staff concluded that the management of Rubie Rogers' assaultive behavior should consist of firm control prior to the assault, while her behavior was still escalating. Plaintiffs' Ex. 9, Doc. No. 500140.

G-20. Rubie Rogers' mental state varied from being paranoid, to being assaultive, to being suicidal, although usually not at the same time. Tr. 56 at 41 (Cacciola).

(II.) *LIABILITY*

(F.) *Medication-General*

(1.) *The Prescription of Anti-Psychotic Medication for Rubie Rogers was Appropriate and Necessary to her Treatment.*

G-70. Given the present state of knowledge of schizophrenic illness, anti-psychotic medications are a necessary element in both inpatient and outpatient care of Rubie Rogers. Tr. 63 at 45 (Myerson).

G-71. When Rubie Rogers was not receiving psychotropic medication, her mental status deteriorated, and she decompensated. Plaintiffs' Ex. 9, Doc. Nos. 500020, 500027A, 500033, 500146, 500139.

PR-7.) When Ruby Rogers refused her medication in the Spring of 1975, the May Unit did not seek guardianship in order to obtain someone else to approve of her medication; nor did they seek to commit her on the grounds that she was both mentally ill and unable to take care of herself on the outside.

PR-8.) After the lawsuit which established Ruby Rogers' right to refuse medication Dr. Seil agreed to change her medication, Haldol, about which she had been complaining, to Moban, which she agreed to take.

PR-9.) Ruby Rogers did not refuse all medication but only medication which she felt was harmful to her. Once the hospital had to listen to her complaints they were able to change the medication to something that she was willing to take. The medication itself may have been beneficial to her in terms of controlling her mental illness and in assisting her in working her way out of the hospital. However, the way in which the hospital chose to deal with her problems acutally undercut rather than enhance the likelihood that she would take that medication. (G-71, 72, 73, 74, 75, 76, 77, 78.) (P-Messinger-TR. 35-47, 56, 57.)

G-72. When Rubie Rogers refused medication, she also refused other forms of treatment available at the May Unit. Plaintiffs' Ex. 9, Doc. Nos. 500033, 500146.

G-73. When Rubie Rogers was refusing her medication while a patient at the May Unit, she was assaultive. She was also self-destructive in her lack of concern for her personal health, nutrition and hygiene. Tr. 58 at 15, 16 (Seil).

G-74. When Rubie Rogers did not take medication while outside the hospital, she broke into buildings, roamed the streets, and was often returned to the May Unit by police because of her disorganized behavior. Plaintiffs' Ex. 9, Doc. No. 500027A.

G-75. In the spring of 1975, when Rubie Rogers refused medication and other therapeutic interventions from the staff, she left the hospital on two occasions, each lasting approximately 10 days. She was returned to the hospital both times the police, and upon return, she was extremely dirty, dishevelled, barely clothed, barefooted, thin, had not been eating well, and was not willing to cooperate with what the staff thought was a reasonable treatment program for her. Upon her second return, she had developed gastrointestinal distress, vomiting, and a fever, which required that she be transferred to the Lemuel Shattuck Hospital. Tr. 58 at 13, 14 (Seil).

G-76. Rubie Rogers was able to recompensate while she was receiving anti-psychotic medications. Plaintiffs' Ex. 9, Doc. Nos. 500003, 500139.

G-77. Anti-psychotic medications helped to alleviate Rubie Rogers' mental illness somewhat; while she was receiving medication she was rather pleasant and affable. Tr. 63 at 44, 45 (Myerson).

G-78. As even plaintiffs' expert testified, whether Rubie Rogers takes anti-psychotic medication contributes to her mental status and her ability to function outside of the hospital. Tr. 35 at 72, 73 (Messinger).

(G.) *Medication-Informed Consent*

(1.) *Rubie Rogers Consented to Receive Anti-Psychotic Medications, Including the Intramuscular Administration of Anti-Psychotic Medications.*

G-79. Rubie Rogers was a voluntary patient during those periods when she was a patient at the May Unit between January, 1973, and May 1975. Tr. 27 at 93 (Rogers).

G-80. As a voluntary patient, Rubie Rogers signed an Application for care on a Conditional Voluntary Basis upon her admission to the May Unit, which included consent for treatment, including the injection of medications. See, e.g., Plaintiffs' Ex. 9, Doc. Nos. 500014, 500016.

G-81. There is no notation in Rubie Rogers' May Unit records that she did not want to take the medications which had been prescribed for her from January, 1973, to April 25, 1975. Tr. 63 at 36 (Myerson).

(C.) *Medication—Informed Consent*

PR-10.) It was not the practice of the May Unit to indicate in a patient's records that they did not want to take medication that they would actually be coerced into taking. (G-81.)

G-82. As she herself testified, Rubie Rogers only 10 or 15 times took Haldol when she did not want it. Tr. 28 at 26 (Rogers).

G-83. At times when Rubie Rogers was admitted to the May Unit, she acknowledged her need for anti-psychotic medications. Plaintiffs' Ex. 9, Doc. No. 500012.

G-89. When Rubie Rogers refused the anti-psychotic medications prescribed for her, she was not given intramuscular medication against her will if she was in control of her behavior and not in danger to herself or others. Plaintiffs' Ex. 10, Entry No. 41; Plaintiffs' Ex. 9, Doc. No. 500133; Plaintiffs' Ex. 9, Doc. No. 500122A.

PR-13.) Ruby Rogers was threatened with intramuscular medication which had the effect of coercing her into taking it against her will even if she did not have to submit to a needle in order to receive it. (G-89.) (P-ROGERS-TR. 28-3, 24, 26.)

G-90. If Rubie Rogers was not out of control and refused to take the oral anti-psychotic medications prescribed for her, she was not involuntarily or forcibly medicated and was not given the medication. Tr. 68 at 129, 137 (Ford).

G-91. While Dr. Cacciola was a resident at the May Unit, if Rubie Rogers refused medication and, after talking with her about her fears, Dr. Cacciola assessed that she was in reasonable control of herself, her refusals of medication were honored. Tr. 56 at 45 (Cacciola).

G-92. Rubie Rogers received intramuscular anti-psychotic medication only in situations when she was secluded following assaultive behavior (Plaintiffs' Ex. 9, Doc. Nos. 400059; 500062; 500065) or when she was unable to control her behavior (Plaintiffs' Ex. 9, Doc. Nos. 400058, 500067, 500074, 500071, 500127, 500094, Plaintiffs' Ex. 10, Entry No. 35.)

G-93. Rubie Rogers was involuntarily or forcibly medicated with anti-psychotic medication only when she was a threat of danger to herself or others. Tr. 68 at 131 (Ford).

G-94. Rubie Rogers received intramuscular medication against her will only when she was out of control, extremely agitated, assaultive and threatening assault. Tr. 56 at 41, 42 (Cacciola).

G-95. There is no testimony by any of plaintiffs' staff witnesses that Rubie Rogers was forcibly or involuntarily medicated in an alleged non-emergency.

. . .

G-99. In response to her complaints about medications, Dr. Cacciola evaluated Rubie Rogers to see if she was receiving side-effects from the anti-psychotic medications she was receiving. Tr. 56 at 43 (Cacciola).

G-100. The physicians of the May Unit evaluated and changed Rubie Rogers' medication and noted in her patient records the results achieved by the medications and the reasons for changes. Plaintiffs' Ex. 9, Doc. Nos. 500003, 500004A, 500006, 500009C, 500018, 500019, 500026, 500026A, 500031.

G-101. Cogentin was prescribed for Rubie Rogers by the physicians of the May Unit in response to restlessness and pumping motions of the legs (Plaintiffs' Ex. 9, Doc. No. 500019) and akathisia and muscle stiffness (Plaintiffs' Ex. 9, Doc. No. 500031).

G-102. As even plaintiffs' expert testified, the prescription of Cogentin for Rubie Rogers by the physicians of the May Unit was the appropriate and acceptable response to her complaints of restlessness and frequent pumping motions of the legs. Tr. 31 at 77 (Messinger).

G-103. As even plaintiffs' expert conceded, Rubie Rogers received considerable medical attention while a patient at the May Unit. Tr. 32 at 101 (Messinger).

G-104. The physicians of the May Unit responded to Rubie Rogers' complaints of side-effects from medication. She received antacid and compazine for nausea. She was given thorough medical checkups. From time to time she was given Cogentin. Tr. 63 at 32 (Myerson).

G-105. The side-effects of anti-psychotic medication which Rubie Rogers did experience between January 1, 1973, and April 25, 1975, did not warrant a change in the type of medication she received. It was not unacceptable medical practice for the physicians of the May Unit not to have changed her anti-psychotic medication once these side-effects appeared. Tr. 63 at 31, 33 (Myerson).

G-106. It was not unacceptable medical practice from January 1, 1973, to April 25, 1975, to have involuntarily medicated Rubie Rogers with anti-psychotic medications once she began to complain of side-effects from these medications. Tr. 63 at 33, 34 (Myerson).

(H.) *Response to Physical Complaints*

(2.) *The Physicians of the May Unit Responded Appropriately to the Neutropenia Experienced by Rubie Rogers.*

G-107. Following her treatment for a neutropenia in December, 1972, Haldol was prescribed for Rubie Rogers because a clinical judgment was made that it is less likely to cause blood dyscrasias than do the phenothiazines. Plaintiffs' Ex. 9, Doc. No. 500003, Tr. 32 at 87, 88 (Messinger).

G-108. Following her treatment for a neutropenia in December, 1972, Haldol was prescribed for Rubie Rogers after consultation with and the approval of Mark J. Brauer, M.D., member of the staff of the Tufts Hematology Laboratory at Boston City Hospital. Plaintiffs' Ex. 9, Doc. No. 500157.

G-109. In her subsequent hospitalizations at the May Unit, the physicians there maintained a continuous awareness that Rubie Rogers had a history of neutropenia and ordered regular laboratory tests to monitor her blood count. Plaintiffs' Ex. 9, Doc. Nos. 500003, 500004A, 500037, 500039, 500119, 500042, 500043, 500009B, 500044, 500046, 500047, 500048A, 500020, 500020A, 500050, 500053.

(III.) CAUSATION

(A.) *Rubie Rogers' Problems Were Caused by Her Mental Illness.*

G-119. The prognosis for Rubie Rogers on January 1, 1973, was very severe. This prognosis did not change between January 1, 1973, and the spring of 1975. Tr. 63 at 43, 44 (Myerson).

G-120. It was the nature of her illness that one of Rubie Rogers' basic wishes was to be left alone, to a point where she is unable to survive. This is not unusual among certain groups of schizophrenics. Tr. 63 at 26 (Myerson).

G-121. Rubie Rogers' illness caused her to refuse treatment offered by the May Unit. Tr. 63 at 36, 37 (Myerson).

(B.) *Rubie Rogers' Problems Were Caused by Her Refusal of Treatment, Including Psychotropic Medications*

G-122. Staff members of the May Unit attempted to encourage Rubie Rogers to become involved in activities such as group activities, occupational therapy and the milieu therapy offered by the May Unit, but she usually refused to participate in these activities. Plaintiffs' Ex. 9, Doc. Nos. 500006, 500009E, 500010, 500015, 500021, 500030, 500031, 500033, 500051A.

PR-14.) One of Ruby Rogers' major problems was her reluctance to accept treatment. However, the treating staff had the responsibility to encourage her to accept treatment including medication. Encouragement

is not the same as coercion. Coercion in fact undermines a patient's willingness to cooperate by establishing a therapeutic alliance and thereby working with the staff towards improving the patient so that the patient may ultimately be released from the hospital. (G122, 123, 124, 125, 126, 127, 128.) (P-Messinger-TR.31-47.)

G-123. When the physicians of the May Unit determined that Rubie Rogers might benefit from Lithium treatment (Plaintiffs' Ex. 9, Doc. Nos. 500004A, 500004B) and, therefore, began her on a course of Lithium treatment (Plaintiffs' Ex. 9, Doc. Nos. 500006, 500009A, 500042), she refused to participate in that treatment by refusing the requisite blood tests. Consequently, Lithium had to be withheld and stopped. Plaintiffs' Ex. 9, Doc. Nos. 500009C, 500044, 500139.

G-124. Rubie Rogers refused to cooperate in the staff's effort to provide her medical treatment. She often refused to have laboratory work done and to keep appointments with physicians. Plaintiffs' Ex. 9, Doc. Nos. 500165, 500170, 500018, 500021.

G-125. When Rubie Rogers refused medication in the spring of 1975, she at the same time refused to sit down and talk with staff and to join in ward meetings and group meetings. Tr. 58 at 14 (Seil).

G-126. Despite her need for treatment, including medication and personal contact, Rubie Rogers began refusing medication, individual treatment, and group therapy following the issuance of the temporary restraining order. She became physically and verbally abusive to patients and staff, and left the hospital on May 7, 1975. Tr. 56 at 46, 47 (Cacciola); Plaintiffs' Ex. 9, Doc. Nos. 500033, 500146.

G-127. When Rubie Rogers was discharged from the May Unit, she refused follow-up outpatient care and stopped taking the anti-psychotic medication prescribed for her, decompensated, and required admission to the May Unit once again. Plaintiffs' Ex. 9, Doc. Nos. 500003, 500004, 500020. 500027A, 500139.

G-128. Whether Rubie Rogers takes medication is one contributing factor to her mental state and her ability to function while out of the hospital. Tr. 35 at 72, 73 (Messinger).

G-130. The involuntary medication of Rubie Rogers did not cause her to be resistant to follow-up outpatient care after leaving the hospital. Tr. 63 at 30, 31 (Myerson).

G-131. The medication practices of the May Unit from January 1, 1973, through April of 1975, were not a contributing factor to Rubie Rogers' unwillingness to participate in the treatment programs of the May Unit. Her refusal to participate was a manifestation of her illness, an inordinate wish to be left alone. Tr. 63 at 48 (Myerson).

* * *

(H.) *Causation of Knots in Her Buttocks*

G-144. The receipt of intramuscular anti-psychotic medications does not cause knots in the buttocks. Tr. 68 at 130, 131 (Ford); Tr. 61 at 56 (Burke-Green).

(I.) *Causation of a Lack of Spontaneity and Motivation*

G-145. Rubie Rogers spontaneity and motivation were not affected by the fact that she received anti-psychotic medication. The lack of spontaneity and motivation represents the basic psychiatric problem of a chronic schizophrenic person. Because of that illness, Rubie Rogers did not have much spontaneity and motivation. Tr. 63 at 28, 29 (Myerson).

(L.) *Many of Ruby Rogers Complaints of "Side Effects" Were Not, in Fact, Side-Effects and Were Not Caused by the Receipt of Antipsychotic Medications.*

* * *

G-151. Rubie Rogers complained of dizziness, stiffness, and other ailments even when she was not receiving psychotropic medication. Plaintiffs' Ex. 9, Doc. Nos. 500144, 500145, 500143, 500003.

G-152. Rubie Rogers experienced stiffness and "shakes" when she was outside the hospital and not taking psychotropic medication. Plaintiffs' Ex. 9, Doc. No. 500003.

G-153. When restarted on psychotropic medication, the symptoms of stiffness and "shakes" disappeared within six days even without anti-parkinson medication. Plaintiffs' Ex. 9, Doc. No. 500003.

G-154. Many of Rubie Rogers' complaints such as stiffness were not drug related, but were caused by her anxiety and fears of leaving the May Unit, as these complaints reoccured when her discharge from the hospital was being planned. Plaintiffs' Ex. 9, Doc. No. 500143, 500003.

G-155. The feeling as though rats were crawling and biting her feet which Rubie Rogers perceived was not caused by and is not a side-effect of Haldol. Tr. 63 at 32, 33 (Myerson); Tr. 60 at 170, 171 (Kahn).

G-156. More probably than not, the feeling as if rats were crawling and biting in her feet was more likely caused by her illness than by her treatment. Tr. 60 at 170, 171 (Kahn).

G-157. Rubie Rogers complained that she felt as if rats were biting her feet even when she was not on anti-psychotic medications. Tr. 68 at 136 (Ford).

G-158. The fact that Rubie Rogers felt as though rats were crawling and biting in her feet was noted by the May Unit staff, who concluded that this was not a side-effect of the medication she was receiving. Tr. 63 at 32 (Myerson); Plaintiffs' Ex. 9, Doc. Nos. 500010, 500006, 500009A, 500009D, 500009E.

G-159. When Rubie Rogers had nausea and vomiting and a fever, she was suffering an infectious process. These symptoms were not in any way caused by Haldol. Tr. 63 at 35, 36 (Myerson); Tr. 60 at 169, 170 (Kahn).

G-160. It is extremely unlikely that Haldol caused Rubie Rogers to have nausea, vomiting, and a fever requiring hospitalization for two weeks. Haldol rarely produces nausea and vomiting, and fever is not a side effect of Haldol, but indicates the presence of a gastroenteritis or some other kind of infection. Tr. 60 at 169, 170 (Kahn).

G-161. When Rubie Rogers was seen by Dr. Cacciola for nausea, her vital signs were abnormal and she was quite sick. The likelihood that these symptoms were caused by medication she was receiving is extremely low, since she had been returned to the May Unit by the police the night before and had not been receiving medication for at least two days. Tr. 56 at 44 (Cacciola).

G-162. Rubie Rogers had numerous somatic delusions and made numerous somatic complaints. Plaintiffs' Ex. 9, Doc. Nos. 500010, 500029, 500003, 500009C, 500009D.

G-163. When Rubie Rogers complained to Dr. Cacciola about medications, he re-evaluated her to see if she was experiencing side-effects from the medication she was receiving. Tr. 56 at 43 (Cacciola).

G-164. Between January 1, 1975, and June 30, 1975, Dr. Cacciola observed no clinical symptoms of drug-induced side-effects in Rubie Rogers. Tr. 56 at 43 (Cacciola).

(IV.) DAMAGES

(A.) *Medication Practices*

G-165. Rubie Rogers did not suffer any damage as a result of the medication practices of the May Unit from January 1, 1973, through April 25, 1975. Tr. 63 at 49 (Myerson); Tr. 31 at 87 (Myerson).

PR-19.) The damage Ruby Rogers sustained from the medication practices of the May Unit between January 1, 1973 and April 25, 1975 was primarily an interference with her ability to develop a therapeutic relationship and thereby facilitate her early discharge from the hospital. It also included the experience of side effects that were unwanted. (G-165.) (P-Messinger-TR. 31-47.)

. . .

(D.) *Knots in Her Buttocks*

G-169. Rubie Rogers did not have knots in her buttocks lasting two or three months as the result of receiving intramuscular anti-psychotic medications. Tr. 68 at 130 (Ford).

(E.)*Side-Effects of Medication-Neutropenia*

G-170. Rubie Rogers suffered no damage as the result of the prescription of Haldol for her, following treatment of neutropenia. Tr. 31 at 87 (Messinger).

(F.)*Therapeutic Alliance*

G-171. Rubie Rogers was not capable of forming a therapeutic alliance. The appropriate treatment for her is pharmacological and environmental, with controls of varying degrees being applied when necessary to maintain the patient. The involuntary medication of Rubie Rogers, therefore, did not interfere with any "therapeutic alliance" because that term is not relevant to her treatment at the May Unit. Tr. 63 at 27, 28 (Myerson).

F. *GENERAL FINDINGS IN REGARD TO THE PATIENT POPULATION OF THE AUSTIN UNIT.*

2.) The Austin Unit did approximately 700 evaluations each year and admitted approximately 65 percent of those evaluations. Each year, the Austin Unit admitted approximately 500 patients. (D-*GILL* Tr. 63-104.)

3.) Approximately 60 percent of the 500 yearly admissions were previoulsy admitted patients. (D-*GILL* Tr. 63-104, 105.)

4.) Approximately 40 percent of the admitted patients were having an acute exacerbation of a chronic process. (D-*GILL* Tr. 63-105, 106.)

5.) Approximately 15 percent of the patients were having the first "psychotic breakdown" and first hospitalization. (D-*GILL* Tr. 63-105, 106.)

6.) Approximately 40-50 percent of the admitted patients were long term patients. (D-*GILL* Tr. 63-106, 107.)

7.) The average census at the Austin Unit was from 65-75, although the all-time low was 30-35 patients in the spring of 1974. The highest census was in the 90's. (D-*GILL* Tr. 63-104.)

8.) January 1974 through January 1975, approximately 35-45 patients were on the A/3/4 floor Ward. (D. *KANTAR* TR 11-5.)

9.) About 12 of those patients were considered chronic and they resided at the hospital all the time. (D-*KANTAR* TR. 11-5.)

10.) There are approximately 4 or 5 patients under the age of 20, on the average. (D-*KANTAR* TR 11-5.)

11.) Very rarely would they have a patient under 16, except for every once and awhile. (D-*KANTAR* TR. 11-5.)

12.) Out of the 35-45 patients, about 5 or 10 were essentially mentally retarded. (D-*KANTAR* TR 11-5.)

13.) In 1972, the average length of stay of patients was 17 days; in 1974, the average time in the hospital was reduced to 14 days. (D-*GILL* TR. 63-137.)

14.) According to Dr. Gill, approximately 20-25 percent were "potentially violent" patients. (D-*GILL* TR. 63-107.)

15.) According to Dr. Gill, 3-5 percent of the patients actually engaged in violent behavior periodically. (D-*GILL* TR. 63-107.)

G. *THE STAFFING, HIERARCHY AND ORGANIZATION OF THE AUSTIN UNIT.*

16.) Prior to January 1975, the wards of the Austin Unit were structured into catchment areas, each of which had a ward that patients were assigned to based upon where they lived in the city. There were also three outpatient clinics that were responsible for patients from each area. (D-*SCHILDKROUT* TR. 43-13.)

17.) "In January 1975, because of fewer patients and deinstitutionalization, and in an attempt to create a more cohesive structure, the three wards merged into two; this meant that A-6 and A-4, which were the two wards responsible for patients in South Boston, became one ward which was then called A-3/A-4. A-3 actually became A-6 and went upstairs. That was the ward where patients from Dorchester came." (D-*SCHILDKROUT* TR. 43-13; D-*KANTAR* TR 11-7.)

18.) There were approximately 93 full time, paid staff available to patients from January 1, 1973 to April 30, 1975. (D-*GILL* TR. 63-115.)

19.) Approximately 60-65 full time staff were functioning in a direct care capacity. (D—*GILL* TR. 63-115.)

20.) There were two Medical Doctors on each ward, a staff psychiatrist and a resident psychiatrist. (D-*GILL* TR. 63-118.)

21.) The Austin Unit was very adequately covered with nursing personnel. (D-*GILL* TR. 63-118, 119.)

22.) Dr. Gill was the unit chief, and he would oversee the operation of the whole unit. He was actively involved in what was going on in the various wards and also delegated the responsibilities for overseeing things to Dr. Kantar and the other psychiatrist (D-*KANTAR* TR. 11-6.)

23.) From January 1973 through January 1975, Dr. Gill had primary psychiatric supervisory responsibilities of ward A6 in the Austin Unit. (D-*KANTAR* TR. 11-6, 11-7.)

24.) Dr. Kantar became responsible for one ward when Ward A3 and A4 merged, and Dr. David Curtis became responsible for Ward A6 in January 1975. (D-*KANTAR* TR 11-7.)

25.) Dr. Gill was no longer responsilbe for any particular ward after January 1975. (D-*KANTAR* TR.11-7, 11-8.)

26.) Dr. Kantar, the staff psychiatrist, supervised Dr. Press who was a psychiatric resident from January 1974 until June 1974. Then Dr. Szlyk was the resident from July 1, 1974 until the end of December, 1974. Dr. Schildkrout was the psychiatric resident after Dr. Szlyk, and he was the in-patient resident on the Austin Unit from January 1975 until June 1975. (D-*KANTAR* TR. 11-10, 11-11, lines 21-24; D-*SCHILDKROUT* TR. 43-13-15.)

27.) Layne Erban was the Director of Nursing of the Austin Unit beginning in the fall of 1974. (D-*KANTAR* TR. R. 11-12, 13; D-*HERSCHEL* TR 40-102.)

28.) Layne Erban was responsible for being the administrative nurse for the whole nursing staff; she was responsible for arranging for coverage, coordinating the personnel that would be present in the hospital. She was responsible for

the policies and the kinds of general management of the nursing service that included the attendants as well as the nurses in the units, and made sure the treatment room had adequate coverage. She also participated in the activities of the ward (Ward A6) until the time of the merger. (D-*KANTAR* TR. 11-13.)

29.) During the period that Layne Erban was building nursing supervisor, she had the power to set policy, and she had the authority and the mandate to make sure that the policy was followed. (D-*KANTAR* TR. 11-14.)

30.) Part of Layne Erban's responsibilities were to insure that policies of the Austin Unit were implemented by the nursing staff and the attendant staff. (D-*KANTAR* TR. 11-14, line 25; 11-15, lines 1-3.)

31.) If Layne Erban informed nursing staff and the attendant staff that there was a particular policy, the nursing staff and attendant staff were required to follow that policy. (D-*KANTAR* TR. 11-15.) The nursing and attendant staffs had to follow that policy as enunciated by Layne Erban. (D-*KANTAR* TR. 11-15, lines 12-18.)

32.) If a rule didn't make sense to an attendant, he'd still have to do it if Layne Erban told him to do it. (D-*KANTAR* TR. 11-16, lines 4-8.)

33.) "Layne Erban lets the inpatient residents coming in know how it's been done in the past — since she stays there, and a lot of the residents come and go.And if the inpatient resident resists complying with the past practices, then Layne Erban would bring it to the attention of Dr. Kantar or Dr. Gill." (D-*KANTAR* TR. 11-16, 11-17.)

34.) The head nurse of the wards would have responsibilities delegated by Layne Erban and would more or less be administrative managers of the ward, particularly with regard to time, who was working. (D-*KANTAR* TR. 11-17.)

35.) Bridgit Harron was the head nurse on Ward A6 in 1973-1974. (D-*KANTAR* TR. 11-13.)

36.) The ward administrator, who at times is also the head nurse, would have the responsibility of coordinating the treatment of the patients in conjunction with the resident and often with the social worker on the Ward. The ward administrator would be responsible for insuring that the policies of the Austin Unit were implemented on that particular ward. (D—*KANTAR* TR. 11-18.)

37.) If the ward administrator informed nursing staff and attendants that a certain policy had to be implemented, the attendants and nursing staff were required to follow that policy. (D—*KANTAR* TR. 11-18, lines 18-22.)

38.) On Ward A4, the ward administrator from January to June 1974 was Nancy Mcquaide. (D—*KANTAR* TR. 11-18, 11-19.) In June of 1974, Gloria Puckett was the ward administrator until January of 1975. In January 1975, Lucy Grosvenor became the ward administrator of A3/4. She was a social worker, not a nurse. (D—*KANTAR* TR. 11-19.)

39.) The ward administrators for Ward A6 were Bridget Harron and Lucy Grosvenor from January 1973 until January 1975. (D—*KANTAR* TR. 11-19.)

40.) Lucy Grosvenor supervised the work of the nurses and attendants on Ward A3/4. (D.*SCHILDKROUT* TR. 43-15.)

41.) Dr. Gill was above Lucy Grosvenor in terms of supervisor, as well as the supervisor of the whole nursing staff in the hospital, Layne Erban. (D—*SCHILDKROUT* TR. 43-15, 16.)

42.) The Austin Unit had at least one social worker assigned to each ward. The Austin Unit had a psychologist, at least part-time, assigned to each ward, and a rehabilitation counselor who was in charge of the activity services and who created or developed from the mental health worker positions a group of activity coordinators or activity directors who essentially functioned as occupational therapists on the ward. (D—*GILL* TR. 63-119.)

43.) The Austin Unit also had a large student complement in the building, including social work, psychology, nursing and medical students. (D—*GILL* TR. 63-122.)

44.) The Austin Unit, to complement staffing, developed various volunteer programs, including successfully recruiting students from the Phillips Brooks House at Harvard/Radcliffe to come out to the state hospital and work with patients in the Austin Unit. The Austin Unit had a director of volunteers, with the responsibility to recruit volunteers for the unit. (D—*GILL* TR. 63-123, 124.)

H. *THE MAY UNIT'S HIERARCHY, ORGANIZATION AND GENERAL STAFFING.*

3.) The hierarchy of the May Unit included the Clinical Director, below him the ward Senior Psychiatrist, then below the Staff Psychiatrist was the Resident Psychiatrist. (D—*CACCIOLA* TR. 56-19, 20.)

4.) A separate hierarchy was for the nursing personnel. The Director of the Unit was their supervisor in terms of line of command. Below him was the nursing director, Mrs. Lamereaux. Beneath her were head nurses of each ward. Below the head nurse was a ward L.P.N. and below L.P.N.'s were mental health workers. (D—*CACCIOLA* TR. 56-20,21.)

5.) The responsibilities of the director of the inpatient services at the May Unit were to provide the general clinical supervision for the running of the unit and care of the patients. The director was responsible for the administrative direction of the staff and of the plant.

The director was responsible to provide consultations, supervision over the psychiatrists and nursing staff, to create and implement policies for the treatment of patients and, when necessary, to provide direct clinical care for the patients. (D—*SEIL* TR. 55-78. D—*KAHN* TR. 60-62, 63.)

6. Dr. Kahn was the Clinical Director of the May Unit from 1970 to September 1, 1974. (D—*KAHN* TR. 60-59.)

7.) Dr. William Malamud, who was then assistant clinical superintendent of the Solomon Carter Fuller Mental Health Center, was the acting interim director of the in-patient service from September of '74 until Dr. Seil assumed the position on March 25, 1978. (D—*SEIL* TR. 55-80.)

8.) Dr. Siegel was the clinician responsible for May-3. He was a psychologist. (D—*GOODMAN* TR. 24-18, 19.)

9.) Dr. Osborne was the only chief resident of the May Unit and his supervisory responsibility consisted of meeting with all the residents once a week and he went around to each ward once a week. He met with Dr. Goldbarg and Dr. Goodman during rounds. He made rounds or had discussions about patients early in the morning. (D—*GOODMAN* TR. 24-24, 25.)

10.) Dr. Siegel was primarily responsible for the clinical activities on the ward, May-3. He would supervise the resident psychiatrists on the ward, oversee treatment plans, be available to patients for individual consultation and for psychotherapy. He'd run the ward meeting which was the weekly ward activity, oversee the milieu and be involved in the clinical operation of the ward, be available to staff for clinical consultation, be involved in inservice education and would be part of the policy group that would be developing policies, clinical policies for the whole May Unit.

In addition, with the departure of Dr. Soto, who was the ward senior on May-4, and with her illness, he was available to May-4 residents, Drs. Mazmanian and Cacciola, for consultation; and for a time he conducted the ward meetings over there because the patients really felt the need to have some senior staff person be more of a presence. He supervised, as well, Dr. Holstein who was a resident on May-6 for six months beginning January, 1975. Previously, he had supervised the two residents as well on May-6, Dr. Furman and Dr. Goldsmith. So from the period of January 1975, through May, '75, Dr. Siegel was primarily involved on May-3. But he was

also actively involved on the other two wards, at least to be available for consultation and as well as the two psychologists in the building who were doing testing who needed some supervision and consultation as well as being available to the evaluation unit for consultation.

In the fall of 1974 when Dr. Richard Kahn left as clinical director, Dr. William Malamud took over as acting clinical director although he had other responsibilities at Fuller Mental Health Center. He appointed Dr. Robert Jiminez to be ward director on May-6 but he had other responsibilities. Dr. Soto during this period was very ill with a back injury, so she was in and out.

Beginning July 1st Dr. Seigel supervised primarily Dr. Sanford Pomerantz and Dr. Jean Turnquest who were the residents on ward May-3. Drs. Pomerantz and Turnquest were replaced on ward May-3 by Dr. John Goodman and Dr. Jeffery Goldbarg. In January, 1975 Dr. Seigel continued his other supervision, and added Dr. Mazmanian and Dr. Cacciola from May-4.

11.) Dr. Seigel supervised two psychologists, a Mr. Rob Parker and Miss Lois Bendix. They were psychologists at May-4. (D—*SEIGEL* TR. 49-51.)

12.) The residents on May-3 had the responsibility of a ward on the average of about twenty-five patients. They had responsibilities for approximately half of them in that they were the persons most directly involved with half of these patients and I had the responsibility for meeting with members of the team, patients, and my supervisors, and I am not sure if you want other things. (D—*GOODMAN* TR. 24-11, 13.)

13.) Each resident on May-3 was responsible for the medical and psychiatric care for approximately 12 patients. (D—*GOODMAN* TR. 24-11, 12, 13.)

14.) Dr. Goodman met with Dr. Malamud, the Director of the May Unit, once a week. (D—*GOODMAN* TR. 24-22.)

15.) Dr. Siegel was not directly responsible for the nursing personnel. There was a nursing chain of command. (D—*SIEGEL* TR. 49-53.)

16.) On the ward, May-4, there were three teams functioning and Dr. Cacciola was in charge of one team. The other psychiatric resident, Dr. Mazmanian, was in charge of the second, and a social worker, who was in charge of the third team. (D—*CACCIOLA* TR. 56-18.)

17.) There were two resident psychiatrists on that ward during each six-month rotation period. (D—*CACCIOLA* TR. 56-18.)

18.) Dr. DeSoto was on ward A-4 but was there infrequently. (D—*CACCIOLA* TR. 56-19.)

19.) The patient load for residents on May-4 from January to June, 1975 varied quite a bit, probably from a low of eight or ten patients up to about twelve or fifteen patients. (D—*CACCIOLA* TR. 56-8.)

20.) On the wards there was an intershift meeting when the 7-to-3 shift and 3-to-11 shift joined together to meet and discuss ward issues. They also met on at least a monthly basis when the 11-to-7 and 7-to-3 shifts interfaced for a kind of intershift meeting.

There was also team meetings that came out of this with regular meetings with a resident and the team, the nurses, the attendants, and Dr. Siegel, and would meet to discuss patient care.

21.) On each of the wards twice a week there was a team meeting. Each ward had two or three teams and those teams included patients and staff. (D—*KAHN* TR. 60-82.)

22.) Each ward had an assigned occupational therapist, and those occupational therapists worked on the ward and off the ward, when possible. (D—*KAHN* TR. 60-83.)

23.) The May Unit recruited a lot of student occupational therapists and some physical therapists from Sargent's College. They had somebody conducting dance movement classes on a

couple of the wards and they also hired an attendant, a doctoral candidate, who was a rehabilitation therapist named Ralph Parker, who provided rehabilitation therapy for people on several of the wards. (D—*KAHN* TR. 60-84.)

24.) Dorothy Cox was the head social worker in the May Unit. There were three other social workers in the building she supervised. In 1974 one of those social workers left. Sometime in the early part of 1975 another left. At that point Dorothy Cox began working on ward May-3. (D—*COX* TR. 69-17.)

I. *THE CONTEXT IN WHICH DECISIONS WERE MADE AT THE AUSTIN AND MAY UNITS.*

(A.) *The Patient Population*

J-73. Patients at inpatient units of mental hospitals are very, very sick, disorganized people. They are psychiatrically, the equivalent of patients in the medical intensive care units. Tr. 59 at 97 (Cserr).

J-74. Practicing medicine at a state hospital is like practicing medicine on a battlefield. Tr. 51 at 120 (Olin).

J-74A. While private hospitals can refuse or transfer patients, state hospitals are hospitals at the end of the line for the seriously disturbed patient. State Hospitals cannot shut their doors, when they are full and develop a waiting list, or refer patients elsewhere. Tr. 51 at 13, 47, 50 (Olin).

J-75. Because of increasing reliance on local mental health centers and less reliance on the state hospital, a primary function of the state hospital has become that of dealing with persons who are violent, or thought to be violent. The state hospital, more than ever, has become a facility of last resort. Tr. 60 at 126, 127 (Lamb, "The State Hospital: Facility of Last Resort," *Am. J. Psych.*, Oct. 1977, at 1152).

J-76. In Massachusetts, since 1971, when the Mental Health laws were amended to require a patient to be a danger to himself or others to be involuntarily committed, the number of potentially violent patients admitted to the state hospitals has increased. Tr. 63 at 108 (Gill).

J-77. Recent medical literature indicates that the incidence of violence and violent behavior among hospitalized mental patients is on a dramatic upswing. Tr. 60 at 100 (Kahn).

J-78. State hospitals take patients during their most acute turmoil, while they are on the waiting lists to get into private hospitals. Tr. 65 at 119 (Gill).

J-79. Almost all state hospital patients are psychotic or depressed. Very few, if any, fall within the neurotic illness category. Tr. 35 at 127 (DiMascio).

J-80. Patients admitted to the Austin Unit were in very serious situations, almost invariably very, very sick. Tr. 11 at 160 (Kantar).

J-81. Approximately 40% of the patients at the Austin Unit at any one time were acutely psychotic. Tr. 63 at 105 (Gill).

J-82. Approximately 20 to 25% of the patients at the Austin Unit would be easily triggered into a violent episode. Tr. 63 at 107 (Gill).

B.) *The Need to Prevent Escalating Violence*

J-83. Patients at state hospitals predictably become upset as the result of other patients committing violent acts. Violence breeds violence. One violent act frequently leads to general disruption or chaos on the ward. Tr. 63 at 109, 113 (Gill).

J-84. Any outbreak of fighting or hostility on the ward increased the psychotic anxiety and agitation of other patients who are not participants in the fight. Tr. 56 at 35 (Cacciola).

When a patient begins yelling, swearing or threatening, the psychotic anxiety and agitation of other patients increases. Tr. 56 at 35 (Cacciola).

J-85. On a psychiatric ward, a person who is out of control creates a serious threat of harm to himself or others. Tr. 59 at 35 (Shapiro).

J. *Prediction of Dangerousness*

J-469. A psychiatrist can predict more probably than not that certain behaviors of a psychotic patient constitutes a serious threat of danger when the psychiatrist is familiar with the patient and when those behaviors in the past have escalated into serious threats of danger. Tr. 51 at 11-12 (Olin); Tr. 2 at 58 (Szlyk); Tr. 65 at 125 (Gill); Tr. 14 at 57 (Kantar).

PR-18. The defendants assert "A psychiatrist can predict more probably than not that certain behaviors of a psychotic patient constitute a serious threat of danger when the psychiatrist is familiar with the patient when those observation in the past have escalated a serious set of danger." With regards to this case this presumes that in fact the psychiatrist rather than untrained staff members are making the decisions to seclude and to remove from seclusion. (J-469-470).

J-470. Psychiatrists and trained mental health workers are able to accurately assess the potentiality for violent behavior in hospitalized mental patients. Tr. 60 at 130-131 (Kahn).

J-471. Clinical work in psychiatry is a teaching process on how to predict dangerousness. Tr. 14 at 55 (Kantar).

J-472. The literature that has developed on the inaccuracy of psychiatrists, in predicting future violence is based on the difficulty of predicting how a person presently in one environment (for example, a hospital) will act in another environment (for example, the outside world). Tr. 51 at 11-12 (Olin); Tr. 60 at 132 (Monahan, "Prediction Research and the Emergency Commitment of Dangerous Mentally Ill Persons: A Reconsideration, *Am. J. Psych.*, February, 1978, at 199.)

J-473. There is no reported or published research which concluded that psychiatrists or trained mental health workers are unable to accurately predict violence in emergency situations. Tr. 60 at 133 (Kahn).

PR-19. Dr. *KAHN* asserts that there is no reported nor published research which concludes that psychiatrists or trained mental health workers are unable to accurately predict violence in emergency situations. He does not offer support to conclude that they can, however. (J-473; D—*KAHN* TR. 60-133.)

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